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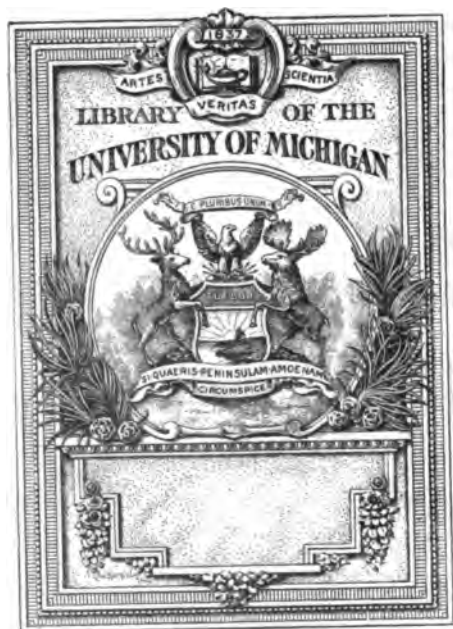
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OBSTETRICS

Gynecology and Pedology

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EDITED BY  
GEORGE WILLIAM WINTERBURN, PHAR. D., M. D.

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EDITOR, GEO. W. WINTERBURN, M. D.

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## ORGANIC NERVOUS AFFECTIONS OF INFANCY AND CHILDHOOD.\*

BY

JOSEPH T. O'CONNOR, M. D., PH. D.

NEW YORK.

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**I**N considering organic nervous affections of the infant it is, I think, advisable to first dwell upon the anatomical facts of the nervous system of the human being at the time of birth at full term.

At the end of intra-uterine life the nervous system of the young individual is but very poorly developed. Its brain, in shape, is similar to that of the same individual some years later, yet the convolutions are but little more than outline sketches. The primary fissures and their adjoining convolutions are present, it is true, but they are in every sense immature. The secondary and tertiary fissures and convolutions are wanting, and what we know in later life as the great brain tracts are, as we learn from the researches

\* Read before the New York Pedological Society, December 20, 1893.



of Flechsig, in certain directions scarcely begun. Leaving for the moment the central nervous system of the infant at birth, let us turn our attention to the peripheral nervous system. From *a priori* considerations, based upon the experience and observation of mankind in general, we find that the infant at birth is a helpless mass of animated matter, and with such reasoning we can fairly assume that its earliest acts are but reflex ones. Now, as reflex action is commonly initiated by the reception of some sensory stimulus, we would be justified in assuming that the sensory organs of the newly born infant must be well advanced in development. And so they are. From experimental researches we find that the first of the special senses to be acquired is that of taste, which, although absent at birth, is fairly well developed in a very few days. Hence the act of sucking—a motor action—must at first be purely reflex and initiated by the tactile stimulation of the mouth on the introduction of the nipple. Next to the sense of taste develops that of smell—both within a few days of birth.

The eye, as a sense organ of the infant, deserves a few words of special consideration. In all of us the optic nerve contains at least two kinds of fibers, that subserve different functions. One set of fibers carries the light impulses from the retina back to the anterior of the corpora quadrigemina, where they are received by cells that have some connection with cells below, that give rise to the nerve fibers to the sphincter of the iris. This whole reflex arc seems to be complete at the time of birth, for it is found that within a few minutes after birth the pupil contracts when even a moderately bright light is allowed to enter it. With the other fibers of the optic nerve, those that subserve the purpose of vision, experiments have not given such positive results. Yet we must admit that vision as such does not exist during the early days of existence in the world. And the same is true, even for a longer period, of the sense of hearing. Now in all these cases we may assume that the

sense organs proper are fairly well developed, but that delay in their apparent action means simply delay in the development of the related corticle areas.

How is it with regard to the motor tracts, including the peripheral motor nerve fibers? We know, from the researches of Flechsig and others, that the motor tract is but little more than begun at birth; and further, that it is not complete in the brain and cord until about the end of the second year.

The foregoing remarks are intended to be preliminary, and by them we can understand the law of development that has received such brilliant illustration through Von Gudden's experiments. Von Gudden took young animals at the time of birth and extirpated some peripheral organ or part. The animals were allowed to grow to the adult period and then, being killed, their nervous systems were examined, by comparing the two sides. In this way a great deal was learned of the anatomical position of certain fiber tracts. But the experiments taught more than this. They taught a great physiological law, that development of a tract depends upon its being called into activity.

With these conclusions before us, we can readily understand why injury to a part of the nervous system in the infant acts at times so differently from a precisely similar injury in the adult.

We may divide disease of the nervous system (including the effects of mechanical injury) in the infant into three classes: 1. Those beginning during intra-uterine life. 2. Those begun during the process of birth. 3. Those dating from a later period.

In the first class are included maldevelopment, which results in the production of monstrosities with absence of brain or of skull, or with hernia of brain membranes, including at times some of the brain mass. The mode of causation of such faulty development is at present beyond our ken. The cases themselves are readily recognizable and rarely survive.

Internal hydrocephalus of intra-uterine origin is a condition usually not difficult of diagnosis.

The cerebral palsies of children may be of intra-uterine origin, or may be initiated during the process of parturition, or can begin at a later period. Fully a third of the cases belong to the former class, yet in many respects the symptoms in all of them are similar. In those dating from intra-uterine life the causes may be traced in a moderate percentage. Injury to the mother, emotional shock, weakening disease during pregnancy, may each be a cause. In many, perhaps in most cases of intra-uterine origin, evidences of the early beginning of trouble in the brain will be found upon examination. Microcephalia, macrocephalia, asymmetry of the skull bones, the Gothic palate, anomalies of ears, nose, teeth, genitals—all show faulty development, and may be considered as pointing to the intra-uterine origin of the trouble.

During the process of parturition mechanical injury to the child is not infrequently the cause of brain trouble as a consequence of hemorrhage, in the parietal regions most frequently. In all the conditions mentioned in which the motor areas have been affected, secondary degeneration or even non-development of the motor tract is to be expected. In all such cases the presence of paralysis with contractures of flexor type, with exaggeration of deep reflexes in most instances, with convulsions commonly, with defective mental development, with paralytic strabismus, defect or loss of vision or of hearing, there will be no hesitancy in locating the lesion in the brain.

It is remarkable in these cases how unwilling the child is to put the feet to the ground when urged to do so by the nurse: the limbs are drawn up and adducted. Adduction of the thighs is another frequent phenomenon, often of long standing, so that when the child, as it often may, attains some power of walking, it is with the thighs crossed in what is known as cross-legged progression. The frequency of

convulsions would serve to distinguish these cases from paralysis following poliomyelitis anterior, without testing the reflexes or the electro-reactions.

One of the birth palsies is that due to meningeal hemorrhage during the process of parturition. In some instances there was foot or other presentation, so that the head was born last. In cases of head presentation there was some special difficulty involving great and prolonged pressure. Most of the cases are firstborn. The use of forceps has been charged as the cause, but, as Gowers well says, "It is probable that the lesion was the result, not of the use of instruments, but of the conditions that made them necessary." In many cases convulsions, paralysis, and rigidity are seen immediately after birth, or before these symptoms are manifest it may be difficult to bring about signs of life in the child. In many cases weeks or months may elapse before defect of movement is noticed, or it may be that difficulty in learning to walk, or indeed resistance to the nurse's efforts at teaching the child to walk, is the first thing noticed.

In cases that have died there has been found meningeal hemorrhage, oftenest over the convexity and involving principally the central convolutions of both sides; in other cases it may be at the base. As a result of the former there must occur atrophy of these convolutions, with non-development of the motor tracts in great part, and we can thus readily account for the greater paralysis in the legs as well as the spastic symptoms.

Children suffering from such brain conditions often improve very much, but no prognosis can be made of the ultimate degree or limitation of restoration, especially as regards the mental powers; and the great danger of the setting in of epilepsy at or about the period of puberty must always be kept in mind.

Besides the birth palsies of the type already mentioned (due to injury to the brain, direct or indirect) there is one

form of trouble that occurs often enough to have received a distinctive appellation. I refer to Erb's paralysis. It had before Erb's time been already described by Duchenne, and is a pressure neuritis due to the thumb or finger of the accoucheur pressing above the clavicle. In this region the upper cords of the brachial plexus are quite near the surface and can be readily influenced by pressure. When the latter is strong enough or prolonged enough, traumatic neuritis is set up and perhaps much more readily in the, so to say, young and tender nerve fibers of the infant just emerging into the world. The accident may be a serious one, for, as we have already understood in the opening remarks of this paper, development will be retarded by the absence of efforts at motion, and in this way I think can be explained the permanency of the paralysis thus occasioned, when it is not properly treated, and especially when not treated early. I think it worth while to direct attention to this form of paralysis, for it is only a few years since that I read an account of such a trouble which was gravely attributed by the lecturer to a hemorrhage within the cord, the anterior gray matter in the cervical region, thus setting up, so he said, a poliomyelitis. If Erb's paralysis had not been known for decades as a special form of birth palsy, the ingenious reasoning of the lecturer might be permitted to pass, even at the risk of overthrowing all that we have learned of the pathology of poliomyelitis.

Of poliomyelitis I need not more than make mention, as I am sure your own observation and study have given you opportunity enough to know it by heart.

Of the post-natal conditions productive of organic changes in the nervous system of the infant there is nothing to be said, apart from the greater readiness of the child to certain forms of disease, especially those that are infectious. A hemiplegia from heart disease (by embolic occlusion of a cerebral blood vessel) is not different essentially from the same trouble in the adult—with this exception, that in the

growing period of life such a lesion is usually followed by retarded development in the affected limb or limbs. This of course does not occur in the adult where the period of full growth has been already attained. Yet hemiplegia from heart trouble is not the common form in infants. But the readiness of the child to accept infection of many kinds renders it more liable to the secondary results of such infection. Most of the hemiplegias of children during the first and second year seem to be not due to any antecedent trouble of other organs, and, as *post-mortem* examinations have been but few and made only after years had elapsed, the results of such investigation have been too varying to admit of any generalization as to the underlying pathological processes at work. The greater part of the central convolutions have been in some cases found absent, their position being represented by a gap, to which condition the name porencephaly has been given. In other cases the gap was small as if closed by cicatricial contraction; in others the convolutions were small, or indeed a whole hemisphere was so. A goodly portion was undoubtedly due to secondary atrophy, the primary trouble having been, according to some writers, a chronic encephalitis due to vascular changes.

A very remarkable symptom occurs after cerebral hemiplegias in children, but also in conditions of intra-uterine origin. I refer to mobile spasm or athetosis. This trouble, which consists of irregular gradually changing movements of the affected limb or limbs, for the most part not affected by simple rest and in severe cases continuing even during sleep, has unfortunately been termed post-hemiplegic chorea; and, to my knowledge, a diagnosis of chorea has actually been made in one such case. The motions may be described as twisting or writhing, and involve chiefly the upper extremity. The fingers and hand, or even the forearm and arm, are involved in this continuous activity; and in some cases analogous parts of the lower limb are implicated.

It may affect both sides. It has nothing in common with chorea, for, as I believe, it shows affection of the optic thalamus or fibers from it to the motor tract. Yet one observer insists that it is of cortical origin. Nevertheless, it is evidence of brain trouble and it may be the chief symptom, the paralytic evidences being very slight.

Concerning the treatment of the effects of organic lesion in the nervous system of the infant, I can say but little. The first thing to do is to make sure of the diagnosis, and then, if it appears that any important portion of that system be gravely injured, to state frankly what the probabilities are for improvement. I cannot insist too strongly upon the physiological fact that, when a nerve cell or a nerve fiber of the central nervous system is destroyed, there is no hope of its restoration. Why, then, treat the case at all? Well, in the first place, we cannot know that all the cells of a certain cortical area are destroyed, nor that all the fibers of a nerve tract have gone into degeneration. This being so, it is our duty to help them to carry on their work, even if that work can only be done at a disadvantage. But especially since we do not as yet know much of the substitutive power of one part of the brain for another, and as there is some reason for believing that such substitutive power does exist, should we endeavor to aid nature in this direction. And this I believe we can do by our remedies. But just here I must write myself down an innovator, and condemn the selection of remedies simply on the symptoms of the case, in hope of cure. A hemorrhage in or on the brain plows through certain nerve tracts or obliterates certain cortical areas, and certain definite symptoms (paralysis, if the motor tract or motor areas be involved) occur. The symptoms show invasion of the function of certain parts, but the disease is not of those parts. The disease is in the blood vessel that gave way, or in the heart. It is plain that we cannot cure either the nerve tract or the blood vessel or the heart, as far the

present affection is concerned. The mischief is done, and in the case related is irreparable. We must admit the limitation of even the law of similars, as Hahnemann himself says, but while we admit these limitations, we need not sit idly with our hands folded; we can prescribe according to the symptoms, and expect from the prescription a supporting or tonic influence upon the immediately adjoining parts to those actually destroyed, and so help nature to hurry up what she can do. A localized meningitis gives symptoms not of meningitis as a disease-process, but of the nerve cells or fibers irritated. To prescribe according to the symptoms may be here of service, for it may have been that in the proving the symptoms were really due to meningeal hyperæmia (*i. e.*, the beginning of inflammation) caused by the drug. It will take many years before we can treat disease of the central nervous system in the infant—or of the adult either for that matter—homeopathically, but by sticking to our text, and prescribing to our best ability, we shall learn to differentiate by our results and lay the foundation for a wonderful edifice of homeopathic treatment, to be erected by the next generation.

In illustration of the foregoing principles of treatment, the following case may be cited:

Charles X., aged four, was referred to me by the family physician, and from the parents the history was obtained. The mother had had no trouble during the pregnancy. Labor lasted several hours; breech presentation; instruments not used. Infant seemed "all right" at birth. First teeth cut at six months. At eighth month the child had a spasm, lay rigid and seemed to be choking; four months later there was another, lasting half an hour, and from it the child went into a sleep. Following this the spasms were repeated every three months. Before their occurrence he would have a "wild" look and seemed to become "kind of vicious," and lumps came on top of head. In some of the spasms, not in all, he would "work with arms and legs," a thrashing up and down of the body.



Learned to walk at age of fourteen months. After three of the spasms there has been loss of power of walking for some days, the limbs being apparently paralyzed. His speech has always been a little "thick," but when his walking power fails his speech becomes almost unintelligible.

At the date of examination, September 22, 1893, the child was unable to walk or to talk intelligibly, and had some paralysis of the palatal muscles, as in the attempt at drinking the fluid came out through the nostrils. A slight internal strabismus was present. He has the spasms now every day. No asymmetry of face noted, but the forehead shows a remarkable protuberance somewhat to the left of the middle. Pupils small and reaction to light difficult to obtain. Testicles have not descended.

Upon the facts above mentioned, I had no hesitation in stating that the child's trouble was in the brain, or at least within the skull cavity; and from the symptoms of faulty development present, I placed the beginning of the disorder during intra-uterine life; the prognosis of cure absolutely bad. But I also told the parents that I could not tell how much of the trouble was irremediable, and that if the child were mine I should treat him in the hope of bettering some of the conditions present. They wished treatment, and as the symptoms were those of helleborus I gave a vial of this drug in the 6th dilution.

While preparing the remedy, the mother mentioned as a peculiar fact that the milder spells occur during sleep, and that latterly the child dreads going to sleep on that account. This aggravation is a strong one for lachesis, and considering the undoubted vascular character of the trouble, in part at least, I withdrew the former prescription and gave lachesis 30. In six days I received a letter from the father stating: "The boy has improved steadily since you saw him. The improvement has continued each succeeding day. At present he has regained the use of himself entirely, is able to walk and run, can talk, sleeps through

the entire night without a break." The severe attacks disappeared in two days, and the slight ones gradually diminished in frequency and strength. There were no more spells until October 7, when they occurred every hour, and were finally relieved by repeating the medicine very often. The case continued doing well until October 20. The remedy seems to be wearing out, for although there were no severe spells, yet the lighter ones occurred several times a day up to December 15, when he had a severe one, and a severe one every day following until December 18, the date of last report. Helleborus was now ordered.

The special point worth observing in the foregoing statement is, that in a case confessedly of organic character and incurable, a remedy properly selected could do, even for a time, so much as lachesis did here.

I could report other cases in which very great improvement has been effected by our remedies; and to a physician who knows what sorrow parents suffer in seeing the deplorable state of a child so afflicted, the knowledge that much relief can be given in many cases is a partial recompense for his inability to promise a complete cure.

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## INTRA-UTERINE INJECTIONS OF TINCTURE OF IODINE IN ENDOMETRITIS WITH HEMOR- RHAGE.\*

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BY  
EDWIN M. HALE, M. D.,  
CHICAGO.

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FROM time to time for the last twenty years I have reported the favorable results of small injections—or rather instillations—of tincture of iodine in hemorrhage from the

\* Read before the Massachusetts Surgical and Gynecological Society, Wednesday, December 13, 1893.

uterus. The last case which came under my care was one which gave a good illustration of the favorable results of the method.

The patient was a large, fat woman of thirty. Twice, she said, she had been in some hospital in New York for treatment of uterine hemorrhage. She had been given ergot in large doses; had used copious hot douches several times a day; had been curetted several times, but no treatment had been able to arrest the bleeding until after several weeks. She was very much afraid this attack would be a prolonged one, and as she was visiting the World's Fair, she was very anxious about herself.

Her symptoms were heaviness, soreness, and heat in the region of the uterus, with some nausea and pain in the sacrum. Standing, walking, or rocking aggravated the symptoms and increased the flow of blood, which was dark in color. She was losing an ounce or two a day, and had been since the flow commenced, a week after her normal menses ceased. On examination the uterus was found enlarged, tender, and prolapsed. There was much soreness in the vaginal vault and in the ovarian region. The cervix looked turgid and dark red, as if from venous stasis. The cervical canal received a No. 4 sound, but its entrance caused exquisite pain, which radiated all through the pelvis and abdomen. She was ordered three hot douches a day of four quarts each, and given sabina 2x for two days, then hamamelis for two days, then hydrastis for two days, with no improvement in any of the symptoms.

Then, suspending all medicines and douches, I instilled high up into the uterine cavity 10 drops of Churchill's tincture of iodine, which immediately arrested the flow, and in a few hours the painful pelvic symptoms began to improve. On the third day a slight flow appeared, and the iodine was again injected. No uterine colic was caused by the injection, which was made with my modification of Battle's intra-uterine spray syringe. On the third day after the last

injection she went to the Fair and was on her feet several hours, with no return of pain or hemorrhage. I believe this method is the best one to use in treating uterine hemorrhage of a passive nature not depending on intra-mural fibroids or polypi. In cystic granulations it is as effectual as curetting, unless the fungoid growths are very large. I have used these injections in menorrhagia, when from subinvolution the menstrual flow was profuse and prolonged. On the fifth day of the flow, if it showed no signs of subsidence, I have injected one dram of the tincture of iodine if the cervix was open enough to allow it to flow out. I have never had any but good results follow its use in such cases.

I believe the use of intra-uterine instillation of hydrastis, hamamelis, erigeron, ergotine, phenol-iodine, and geranium maculatum should be used more in the treatment of chronic uterine catarrh. Whenever I have resorted to their use I have been much more successful than by the use of internal medicines.

It only requires a few drops to spread all over the intra-uterine mucosa, and any quantity not over 10 drops will not cause uterine colic. The operation should be repeated every five days.

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## PROGRESS IN GYNECOLOGY.

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BY

KATE G. MUDGE, M. D.,  
BOSTON, MASS.

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**I**N the progress of gynecology many old theories have been threatened and many new ones advanced.

In this age of earnest scientific investigations, gynecology has progressed at a wondrous pace. We find that the changes in theory and practice have been more marked in gynecology than in any other department of medical science.

The advanced thought of to-day is the conservatism of to-morrow.

Surgery claims its triumphs more frequently than therapeutics in gynecology.

"Homeopathy to-day is the only system which can claim a rational system of gynecological therapeutics."—G. S. R.

Preventive medicine is the battle cry of the day.

The marked improvements in the *diagnosis* of diseases, and the prompt surgical interference for speedy relief, are the most distinctive features in the progress in gynecology.

Intra-uterine treatment—the tampon—is now generally appreciated.

"Dilatation, curetting and drainage," are the three foundation stones upon which this practice of intra-uterine therapeutics rests; applicable in endometritis, stenosis, hemorrhages, accumulation within the tubes.

The limits of this report forbid an exhaustive dissertation upon any one subject.

The treatment of inflammation of the uterine appendages has been frequently and earnestly debated upon, and at the present time a great diversity of opinions exists. The tendency is toward conservative treatment.

The most prevalent disease of the female generative organs lies in the fallopian tubes. The most frequent form of salpingitis early recognized is endo-salpingitis, which may be catarrhal or suppurative. Salpingitis proper, the inflammation of the muscular wall of the tube, is a secondary process. "As salpingitis proceeds the product of inflammation infiltrates the muscle and degenerates the muscle by compression, and the thick walled tube is simply inflammatory products."

Inflammation of the peritoneum covering the tube, or "peri-salpingitis, is easily recognized by traces of old adhesions—flakes of partially organized lymph and roughened points in the tubal peritoneum."

The majority of pelvic inflammations are diseased con-

ditions of the tubes and ovaries caused by extension of disease from the endometrium.

If active and thorough treatment is instituted in the beginning, it is possible to prevent suppuration of the appendages. Certain diseases of the tubes and ovaries are treated surgically without removal of the entire appendage. This with a view to maintain the physiological function of the ovary and tube.

A portion of the ovary or tube must be in a healthy condition to permit this operation.

When the ovary contains pus, it, together with the tube associated with it, must be removed. If the tube contains pus, and the ovary is free from pus or even undergoing cystic degeneration, either the removal of both organs or the partial amputation of the tube leaving the ovary, may be recommended. Formerly whenever a tube contained pus it was removed, but recently cases have been reported, where by drainage through the uterine cavity the tube has been relieved of its purulent material. Thorough curettement must follow. The swelling decreased after treatment by massage, electricity, and local applications, and pregnancy has followed verifying the recovery.

Only such cases are amenable to this treatment where the tubes are open and there are no adhesions present to interfere with drainage into the uterus.

"A cyst or solid tumor of the ovary can sometimes be removed and yet leave sufficient healthy tissue to carry on the physiological function." When a very small portion of ovarian stroma is left, no menstrual changes occur. Many women with adherent tubes or ovaries suffer no real inconvenience, excepting during menses, unless their health break down from over-work or nerve strain, malaria, influenza. Then great suffering may arise from these pelvic lesions.

Operative measures will become more limited when medicine can assert its curative power, as it surely must in the progress of our knowledge.

Many careful researches are made daily into the extent and frequency of serious mental disturbances following the removal of the appendage. A frequent query is whether greater nervous disturbances are caused by the operation than arise from the disease itself. In the field of bacteriology the gonococcus question has excited lively interest. Professor Messer of Breslau is the discoverer of the gonococcus. Great attention has been directed to the careful bacteriological examination of the inflammatory products of the uterine appendages. Gonorrhea is very prevalent in women, and sometimes the uterus, fallopian tubes, ovaries, and their peritoneal covering are seriously affected.

Great danger of this disease is due to the fact that it does not remain localized.

"The virus of the gonorrheal process may permeate the superficial epithelial covering of the organ, and cause deep-seated structural changes."

Early and prompt treatment is recommended, because only in the early stages is it amenable to treatment. Antibacterial application is the best therapeutical measure to be adopted. The discharge must be repeatedly examined to gauge the success of the treatment.

The importance of urinalysis in gynecology has been thoroughly explained by H. Kelley of Baltimore.

He urges the importance of making a careful analysis of catheterized specimens of urine, before and after each and all operations. He says that pelvic disease does not cause renal disease of serious nature in a very large percentage of cases.

Presence of albumen, even in large amounts, is not significant unless casts are present.

The presence of small granular and hyaline casts does not contra-indicate operation unless vascular and associated symptoms indicate renal disease. Diminished secretion following operation is not uncommon, and need occasion

no alarm as to the possibility of a ureter being ligated, or the existence of any serious interference with the renal functions.

Persistent diminished secretion, associated with elevated temperature and increasing rapidity of the pulse, is not due to nephritis, but to septicæmia.

Retro-displacements, when uncomplicated, cause little serious disturbance and require simple treatment—pessaries, tampons. For cases of retroversion with complication, when operative measures are necessary, the best operations recommended are the Alexander-Adams, the various methods of intra-abdominal shortening of the round ligament, and ventro-fixation. Alexander's method is subject to the following limitations: "The uterus must be free; the diagnosis exact; the anatomical conditions favorable."  
—E. W. C.

The importance of the early diagnosis of the presence of fibroma has been emphasized.

Hemorrhage and pain are the principal symptoms; hemorrhage the more dangerous.

Complication is due, according to the recent research of Semb, to an "hypertrophy of the uterine muscles accompanying the myoma with a simultaneous hyperplasia of blood vessels."

Electricity is condemned, excepting in cases where the growths are solid and intra-mural—never applicable when they are subperitoneal or when cystic degeneration exists.

Operations practiced for the radical cure of these growths are vaginal enucleation, removal of appendage to establish an early menopause, enucleation by cœliotomy and supra-pubic hysterectomy. A bright future for hysterectomy in myoma uteri is predicted. Finally we come to the most dreaded affection to which woman is liable, cancer of the uterus. The early diagnosis of this disease is of paramount importance.

Closer attention to-day is paid to the early symptoms,



and many lives are saved by an early operation before the extension of the disease is too great to render the prognosis unfavorable.

A watery discharge should never be disregarded; it is always an early symptom of this formidable disease. Bleeding not so early, pain a much later symptom. Cancer begins as an isolated growth in a particular tissue and progresses by proliferation into neighboring parts, and can be cured only by operation.

Total vaginal hysterectomy is now claimed to be one of the safest and most satisfactory major gynecological operations, and the mortality in favorable cases is slight.

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### VAGINAL HYSTERECTOMY FOR CARCINOMA UTERI, WITH REPORT OF CASE.

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BY

W. E. GREEN, M. D.

LITTLE ROCK, ARK.

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MRS. E., æt. fifty-seven; small, delicate, mother of two children; menstruation ceased ten years ago; consulted me on account of a return of the flow. Upon an examination I found a carcinomatous growth occupying the entire anterior lip of the cervix, which in two places was beginning to break down. A very offensive sero-purulent discharge issued from the os. The uterus was atrophied and movable, and adjacent structures seemed to be free from disease. The vagina was quite small.

I advised an immediate removal of the organ, to which the patient reluctantly consented. Before the day set for the operation, though I had assured her that her chances of recovery were unusually favorable, she went to the cemetery, purchased a lot, and made adequate preparations for her funeral.

At eleven o'clock, August 17, 1893, assisted by Drs. Neal, Hughes, and two nurses, the patient was anæsthetized and placed upon the table. After evacuating and cleansing the rectum and going through the most rigorous details, preparatory to an aseptic operation, the cervix was caught with a tenaculum, drawn down and steadied, while with a sharp curette all friable tissue was cut away; the cavity was then dilated and packed with gauze, to give firmness to the organ and to absorb any septic matter that might be retained therein. All the diseased surface was charred with the Paquelin cautery, after which the anterior and posterior lips were sewn together, completely closing in the diseased structures. The douching process was then most thoroughly repeated, all the protective dressings changed; all basins, sponges, and instruments that had been used up to this time, were set aside.

Seizing the cervix with a heavy vulsellum the uterus was drawn well down, while with a pair of sharp-pointed scissors, an incision was carried entirely around the cervix, fully one-half inch within the bounds of healthy tissue, severing the mucous membrane and vaginal muscular tissue; posteriorly the cutting was continued upward until Douglas' *cul-de-sac* was opened, into which a sponge, with thread attached, was inserted, to keep back the intestines and to absorb the blood that might otherwise escape into the pelvic cavity. While an assistant strongly deflected the cervix to the right, the index finger of the left hand was introduced up behind the left broad ligament, as a guide, and with a strongly curved needle a medium-sized cat-gut ligature was passed around its base and snugly tied with a treble knot. This ligature was introduced fully one-third of an inch away from the womb, laterally, so that in severing the tissue it would have a good hold and not slip, and permit the cutting to be done well away from the diseased uterine structures. It embraced fully three-quarters of an inch of the lower border of the broad ligament

and included the uterine artery. The right side was then treated in a like manner, after which, the uterus was severed from its attachments on either side, up to the limits of the tissues secured by the ligatures. The uterus was now further dragged down and held backward, and the anterior vaginal attachments rapidly dissected up, until the cellular tissue, that loosely connects the uterus with the bladder, was released. The further separation was accomplished with the finger, and the peritoneum opened. Another ligature was now applied on either side, but closer to the uterus, that reached half an inch further up and included a portion of the tissue grasped by the preceding ones. The portion of ligaments secured by these was snipped away, which gave to the organ much greater mobility. The fundus was now retroverted, and the left ligament tied in small sections from above downward, five ligatures in all being used. After it was entirely severed, the right side was treated in a like manner, though it was much easier to accomplish.

There was considerable bleeding from the posterior vaginal wound; therefore the mucous membrane and the peritoneum in this region were united by a continuous cat-gut suture. The sponge that had been introduced into the pelvic cavity was removed, and the parts thoroughly douched with warm sterilized water. The cut surfaces of the broad ligament were then drawn down into the vagina, a suture applied in either angle, to sustain them in this position, the peritoneum closed, and the anterior and posterior vaginal walls approximated with two other sutures. The ligatures, that had been purposely left long, were cut short, the vagina dusted with iodoform and carefully packed with sterilized gauze. A large, clean sponge was now placed over the vulva, to prevent soiling of the dressing, and held in position by an assistant. With a bivalved rectal speculum, the sphincter and muscles were dilated and three large hemorrhoidal tumors, three pockets,

and two papillæ were removed. I did not deem it prudent to subject the patient to the additional shock of an excision; therefore, after clipping away the pockets and papillæ, the tumors were successively grasped by a strong pair of toothed, thumb forceps; while the point of the scissors was entered at the anal verge and the gut slit up on either side of the tumors as high as the internal sphincter, with a few snips of the scissors they were cut away close down to the muscle, leaving an elliptical incision. Each of the gaping wounds was then closed with two small cat-gut sutures. This is an admirable way to remove large hemorrhoids when an excision is not desirable.

A large absorbent pad was now applied to the vulva, that was retained in position by a T-bandage, and the patient put to bed. She rallied promptly, but complained of considerable pain in the back and hips; one-fourth of a grain of morphine was given hypodermatically, which gave relief, and she rested well during the entire afternoon and night. At 9 A. M. the next day her temperature registered 99 (this was on the 15th), at 6 P. M. 99.6; on the 16th, at 9 A. M. 99.8, at 6 P. M. 100; on 17th, at 9 A. M. 99, at 6 P. M. 99.6; 18th, at 9 A. M. 98.6 and thereafter it remained normal.

On the morning of the fourth day a saline purge was given, that gently moved the bowels. On the sixth day the packing was removed from the vagina and a bichloride douche given. As there was no formation of pus, it was reapplied and left in position for three days, when it was removed and the douching repeated; this was now continued night and morning until all discharge ceased. The patient sat up on the fourteenth day, and in a few days thereafter was walking about.

This is a typical recovery after a vaginal hysterectomy. It is astonishing how little constitutional disturbance follows, and how rapidly a patient recovers from the operation. During the past six years I have operated repeatedly with both the ligature and clamp, but prefer the former method.

I have never lost a patient after either, nor have I ever had one die from secondary infection. I consider the animal ligature superior to the silk; if properly manipulated it is safer, since the danger of sepsis through ligature infection is avoided. The ligatures are cut short and are readily absorbed, thereby avoiding the pain and inconvenience incident to their removal. The surgeon should always test the strength of the ligatures before beginning an operation, so that too much strain may not be put upon them; by so doing he will avoid the delay and vexation incident to breakage. It is not necessary to put as much tension upon them as advised by many works on surgery. If too great an amount of tissue is not included in the grasp it is not necessary to draw them so tight.

Drawing the broad ligaments well down into the vaginal wound and uniting them with ligatures, then closing the peritoneal and vaginal rents, are important features of the operation. It turns the raw surfaces out of the pelvic cavity, forming a strong key of support to the pelvic viscera, prevents intestinal adhesions, and removes an element of peritoneal infection. The vagina is left much deeper after this procedure.

Absolute asepsis is a most important element of a successful hysterectomy. All the friable tissue should be cut away with a sharp curette, after which the surfaces should be thoroughly charred with a Paquelin cautery and the anterior and posterior lips united by a continuous suture, completely closing in or sealing up, as it were, the diseased parts. Then the entire vaginal surface should be smeared over with a strong chloro-phenique or a campho-phenique solution; this is to be followed by a plentiful douching with bichloride solution, 1-2000. If the cleansing has been thoroughly and systematically done, and all details of antiseptic surgery have been observed throughout the operation, septic infection and consequent death will rarely occur.

The vaginal tampon, if protected from urinary infection, can be left undisturbed for six or seven days. By that time the parts will have united, the stitches been absorbed, and the patient practically well. It should be removed, however, at any time, if the discharge becomes offensive.

A preparatory curetting, done a few days before, is not advisable. Some time ago I had two cases come to me in one week for operation, where the cancerous growth was very extensive; and the left broad ligament in both cases was thickened, though the uterus was somewhat movable. I thought that if I curetted, the zone of inflammatory thickening would be diminished, and the condition would be more favorable for a successful operation. To my surprise increased inflammatory products were thrown out, and the organ was rapidly bound down by adhesions. While the suffering was abridged and the septic condition temporarily checked, the case was spoiled for a radical operation. With increased experience I would now operate upon both cases, for I believe it could have been safely done and would have saved much suffering and given a chance for recovery.

I recently excised a portion of a cancerous cervix, for microscopical examination, where but slight affection existed, closing the wound with two sutures. Ten days later, when I went to remove the organ, I found that a most rapid extension of the disease had followed the procedure, and the case was almost spoiled for a successful operation. Dilatory measures are not to be countenanced in the management of cancerous conditions. Early and radical measures are demanded; no treatment short of complete extirpation will answer. The operation for an experienced surgeon, dextrous in the use of instruments, is easily accomplished, can be performed in from twenty to forty minutes, and is seldom attended with fatal results.

INDICATIONS AND CONTRA-INDICATIONS FOR  
TRACHELORRHAPHY.

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SINCE eminent authorities have said that more than one-half the ailments of women who have borne children are to be attributed to lacerations of the cervix, its medical or surgical treatment should receive that careful attention its importance would seem to require. Trachelorrhaphy was first performed by Dr. Emmet in 1862, and is known as his operation. At that time the majority of the medical profession were skeptical as to its merits. At the present day the realm of this operation is recognized by most gynecologists, although they may not all agree with Dr. Emmet that so large a proportion of uterine disease is due to torn cervixes.

But there is far from one voice upon the subject by the general practitioner, who does not have the opportunity of studying these cases nor of keeping them under observation both before and after operation. The advice of the gynecologist, that a torn cervix should be repaired, is often opposed by the family physician, who has referred the patient to the specialist for examination, and will then not allow her to submit to the proposed operation because he does not believe in it. Lawson Tait, on p. 105 in his last edition of "Diseases of Women and Abdominal Surgery," says: "Laceration of the cervix is a mere accident, which is of not the slightest consequence in itself. A great flood of operations has in consequence gone through the practice of gynecology of recent years for the stitching up of this innocent fissure. Nothing more useless than Emmet's operation has ever been introduced into surgical practice."

With a statement like this from such an eminent surgeon as Mr. Lawson Tait it is not surprising that trachelorrhaphy still has its opponents; but it *is surprising* that one as conversant with uterine pathology as Mr. Tait should make such a statement.

This paper, therefore, is not intended for the specialist, but to throw out a few hints to those who are not specialists in diseases of women in reference to the importance of trachelorrhaphy, and to show what a large factor a torn cervix is in many of the local diseases as well as in some of the neuroses of women. In order to appreciate or rightly estimate uterine disease, the remarkable nervous arrangement of the pelvic organs should be constantly borne in mind, as well as the anatomical structure and physiological peculiarities of the uterus.

The very intimate connection of the uterus with the sympathetic system, and in the cervix with the cerebro-spinal system, incloses it within the center of a circuit where the internal resistance, often from normal as well as abnormal conditions, is voiced either by local tissue changes or reflex nervous disturbances. The free circulation of blood in the uterus, the arteries being large and tortuous, the veins without valves and being easily compressible, and added to this at regular intervals the physiological congestion of the whole organ, in these we have adequate cause in normal structure and function for many local as well as remote disturbances. The great glandular activity of the cervix predisposes it to inflammation, and its position renders it especially liable to injury. With a tear in its tissues increasing the surface exposed to irritation, the effect on the whole organ is to induce an engorgement with resulting enlargement—changes in the uterine mucosa producing endometritis and endocervicitis with uterine catarrh—menorrhagia or metrorrhagia—and often sterility. By the continued hyperæmia the growth of fibroids is favored; and by the degeneration of these, cancer. The prolonged



hypernutrition will frequently terminate in hyperplasia, and finally a true sclerosis, with amenorrhœa and dysmenorrhea. With these structural changes in the uterine tissue there may be an accompanying mental depression or an irritability of the nervous system, rendering the patient a constant sufferer and anything but a comfortable companion.

In view of these possible remote results the question arises, Shall we operate upon *all* torn cervixes, and at what period of time after the accident shall we operate? I am far from advocating an operation upon every case. When there is only a slight tear, with no eversion of the mucous membrane, an operation would not be required unless there should be firm cicatricial tissue in the angle of the wound, and the woman in consequence suffering not only local pain but nervous reflexus from a nerve filament found in the angle of the wound. The spinal irritations and reflex paralyzes in these cases I believe to be due to a neuritis arising in the imprisoned nerve and extending to the cord. The quickest method of relief here would be by operation, and it could be advised with a hope of more than a fair measure of success. But if the patient objects to operation and is willing to submit to a more prolonged treatment much can be done, and I feel I do not go too far in saying the patient cured, by galvanism. The negative pole should be placed directly in contact with the scar tissue, and the positive on the sacrum, and a current of 30 or 40 milliamperes used for fifteen minutes three times a week. By a continuation of this treatment for six weeks or two months the cicatricial tissue will soften and lessen the pressure on the incarcerated nerve.

There are also cases of slight laceration accompanied by displacement, that can be markedly benefited by treatment that will restore the uterus to its normal place in the pelvis. Lifting the organ to where it belongs will restore the circulation and prevent the blood stasis which is causing

the profuse glandular secretion, rendering the woman anæmic and hyperæsthetic. By a preliminary treatment with local applications of boro-glyceride, or glycerine and bell. on wool or cotton until the tenderness which is generally present has subsided and the engorgement lessened; then by a suitably applied pessary the patient may get on without an operation; more especially is this to be recommended if the patient is a young child-bearing woman. I say a suitably applied pessary; by that I mean one that will not only hold the uterus in position, but will not stretch the already divided lips farther apart. I do not mean to say that the laceration will be cured by the treatment and the pessary, only the necessity for the operation will be avoided, at least for a time. Neither the galvanism nor the pessary is to be recommended if the laceration is sufficient to cause an eversion of the lips; a prolonged treatment here, especially by caustics and pessaries, is only to be condemned, as I believe in many instances uterine cancer has been produced.

If the local inflammatory theory of Virchow is now the most generally accepted one in regard to malignant growths, and an endo-cervicitis is one of the most frequent sequelæ of laceration of the cervix, our duty to our patient who sustains a cervical laceration with eversion of the lips is to protect that wound from injury or irritation, and prevent, if possible the development of malignant disease. This can *only* be done by operation; and more especially should this be urged if there is a history of malignant disease in the patient's family, either near or remote.

As one of the predisposing causes of uterine cancer laceration of the cervix occupies a much more conspicuous position than was formerly supposed. I believe if Lawson Tait did not consider trachelorrhaphy too small an operation for so great a surgeon as he is to perform, he would not have so many uterine appendages to remove. With an endometritis as one of the early sequelæ of a torn cervix,

is it not quite possible for a salpingitis to be classed as one of the later sequelæ? With the intra-uterine treatment that is so common in affections of the endometrium, if not given under the most careful and strictly antiseptic methods, a salpingitis can easily be produced; and a woman with a salpingitis is in a much more hopeless condition, in regard to cure and to her future, than one with a torn cervix, if the *latter* receives proper treatment at the proper time.

I recognize the necessity of treating the endometrium, in some cases previous to, and in others at the time of, the operation—but the constant treatment of the interior of the uterus, while the cervix remains unrepaired, is hazardous and often useless. In the majority of cases the endometrium would take care of itself if the cervix was closed. Nothing is more destructive to the sexual life of a woman than a salpingitis—and in every woman who has a torn cervix and develops pain in the groin with symptoms of tubal trouble, the cervix should first be closed and await results. Then if the pain in the groin and all the attendants of tubal trouble are not relieved, the removal of the appendages can be done later.

I would not undervalue Mr. Tait's operation, nor deny the necessity for it in many cases; but the slow development of tubal trouble, in the presence of a laceration with an accompanying endometritis, I believe to be due to extension by continuity to the tubes from the endometrium, and that these cases should first receive the minor operation of trachelorrhaphy.

In reference to the immediate repair of cervical tears every case must be a law unto itself. The objections are apparent; also the advantages. If every cervical tear could be immediately closed, we would have a fewer number of women complaining of uterine trouble after confinement. By closing the wound involution of the uterus would be more complete, and union by first intention more apt to take place. The healing of wounds by granulation

always leaves a scar, and in these cervical tears it is the firm scar tissue binding the filament of a nerve and by its pressure causing pain, and by its contractions lateral displacements.

If uterine disease is more frequent now than in former days, and so large a per cent. attributed to laceration of the cervix, may we not find a solution of the matter in the tendency at the present day to the encouragement of rapid labor? If the laceration of the cervix is of such serious import, is it not as much the duty of the accoucheur to prevent its being injured during labor as it is to devote so much attention to the perineum? The internal injuries are of much more serious consequence than the majority of external ones, as the latter can be closed at once and the integrity of the parts restored during the lying-in period, while the tears in the cervix, if not immediately repaired, retard the woman's recovery and are followed by such a variety of pelvic troubles.

The early rupturing of the membranes, the encouraging of the woman to exert herself in bearing down before sufficient dilatation, the stretching of the anterior lip over the presenting part, the early administration of ergot, would all tend to force the soft tissues to give way. Any means used to hasten the passage of the presenting part through the cervix, before it is dilated, will endanger it. The use of forceps all recognize as liable to do injury.

We all know how tiresome a tedious case of labor becomes when the os is rigid; but with the resources we have in our variety of remedies and in the use of elastic dilators we should avoid, as long as may be safe for our patient, resorting to any means that would be liable to result in the accident to the cervix that is followed by so many ailments, and often by serious disease.

## PRACTICAL PHILOSOPHY.

BY

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THERE are numerous deformities dependent upon the imperfect vital operation of the nutritive system, which should be prevented from repetition at least, and if anticipated at a proper time would rarely if ever occur, were proper therapeutic methods considered and consistent hygiene and dietetics maintained.

If the expectant mother be of a so-called scrofulous diathesis, or having dyscrasies, there is, *per se*, a heterogeneity of tissue, an imperfectly acting digestive, assimilative, or nutritive force (vital force), a deviation from the healthy organism, the effects of which will change the habits, character, and desires of the mother, whose life is to be transmitted to succeeding generations in quality of vital force, nutritive force, as well as moral tendencies produced by a changed organic or systemic action, and whose progeny must be expected to participate in her peculiarities of constitution and forces, to a greater or less extent, depending upon the conditions of life, habits, and association. Such a life associated with an opposite temperament, with strong vital forces, free from all diatheses or disease dyscrasies, may compensate in part, at least, for the tendencies of the maternal side, and thus delay the appearance in the progeny of any or all tissue deformities or anatomical monstrosities; but this condition prevailing in the expectant mother, favored by a like temperament in the husband, will intensify the possibilities for these dreadful calamities. This statement may be reversed as to subject, and say the expectant father, but we all give the whole credit to the mother when the offspring is perfect, and as a matter of

fact, the mother's nutrition and vital forces do affect the development, the form, and characteristics of her offspring, yet it may partake wholly of the paternal side, of his faults or virtues, as well of his physical inherent weakness, which may be (but not often is) changed by the hygienic *régime*, teaching, and ardent love of the mother.

When great infelicity exists in the home life of mothers, whether caused by the perverse nature either of the husband, some uncontrollable condition, or her own nature or incompatibilities, the digestion will be impaired, and of course nutrition will suffer proportionately. Excessive joy or grief is well known to cause anorexia, and even nausea and vomiting. So, if grief be constant from difficulties between the parents, or for other causes which so prey upon the expectant mother that digestion and nutrition be impaired, the effect will be produced upon the vitality of the offspring, even to the extent of physical or mental deformity or both. In this humanity differs from the lower animals, and to this phenomenon too little attention is given by even the scholarly minds of the profession.

To the influences of the mind upon the vitality of the human, depend the life and successes of various species of quackery imposed upon the world, with advantages against the medical profession. Let us study these occult laws by the phenomena produced, and arm ourselves against superstition and charlatanism, and our clientele against the results upon them, and our loss of their confidence.

It is in this field that the so-called law of heredity holds the greatest attraction for all, and affords ready answers to inquiring patients, and relieves the busy doctor from many hours' thought and study, and satisfies the minds of the inquirer, because it appears mysterious.

To prevent this condition of malnutrition, malassimilation, diverted tissue products, anæmia, or weakened vital forces, we would be required to begin with the propagation of our race, for we produce our similar; according to the

nature and tendencies of parents is the progeny disposed.

It seems to me a self-evident fact that medicines which will improve histological development in the mother, will also improve the morphological processes in the embryo; and I also deduce from this self-evident truth that, the nearer perfect the embryo, the fetus, the child, from the anatomical, histological, and morphological conception of typical human life, the nearer perfect will be that life in all its capabilities and character.

If an error of nutrition is manifested in the deformity of the babe, who can determine whether that deformity might not have been obviated, had the true condition been anticipated and proper measures of therapeutics and hygiene prescribed, which would correct the error of nutrition or other processes in the expectant mother (which were evidently wrong), before conception?

If a woman suffers all her life from an error in nutrition, or any of the vital processes, which error having become a part of her life, and escaped her observation as an error or unnatural condition, yet her entire life may have been diverted by this peculiarity, and she changed in conduct, desires, aversions, and character; this profound morbid condition may impress each succeeding generation in increasing proportions, as the generation extends throughout the family history, and until malformations may become apparent, and even repulsive, so-called hereditary diseases become the rule, health the exception.

If remedial agents are applicable to conditions of error in the digestive and assimilative organs, in histological tissues or morphological processes, and if errors in these affect the vital forces, and errors in the vital forces produce errors in the conduct, dispositions, desires, and character; then, why are not remedial agents of utility and of positive value when scientifically directed and rationally exhibited in subjects of these errors? And as these errors appear in

mothers and are manifested in her progeny, why may we not expect the cure of such defects in the mother to be followed by the prevention of consequent deformities in the offspring?

To obtain therapeutics for the improvement of the progeny, for improvement of the human race, is as much to be desired, and is certainly as great work as any we may hope to accomplish; a work worthy of our efforts as physicians and humanitarians, as well as philosophers and philanthropists.

I care not how skeptical he may be in the use of medicines properly and scientifically selected and administered; if intelligent and rational, he will be convinced when the results are manifested. But life is too short, and omissions of this kind become too grievous, to permit them to pass until after such time as all family physicians can be convinced by practical demonstrations, and by their own volition made to acknowledge and direct treatment rationally, and in this manner.

CASE I.—Mrs. B. A. gave me the following history in the year 1881: Was delivered of a healthy child, apparently perfect, and at the expiration of full term, but after a few hours the child was seized with convulsions and died in a few minutes; no *post-mortem* was permitted. In due time she again became pregnant, and at the expiration of her period of gestation, as before, was delivered of an apparently healthy child, which, as before, after a few hours of life and apparent health, was seized with convulsions, and expired precisely like the former infant, the labor in each case being quite natural. In the latter instance an autopsy was permitted, and the physician reported to her that the infant was found to have an imperfectly developed ileum, a slender and imperforate cord, of about three inches in length, connecting the ileum with the cæcum.

The lady herself, quite intelligent, could give no history of unnatural experience or ill health during her period of gestation, or at any other period of her life, more than the



usual good healthy person. She desired to be relieved of her present prospects of again witnessing the terrible death of her offspring. I advised her to submit to treatment and await the result, which I assured her would be best for her, and that I had hopes of overcoming the sad calamity by treatment in the next pregnancy succeeding the present, if not in the present case. She awaited with similar results, although she said by way of encouragement that the child lived several hours longer; no *post-mortem* was permitted, and the mother reported herself improved. The remedies were continued at longer periods; she again becoming pregnant, was at full term delivered of a healthy and well-developed child, who is at this time ten years old, and each succeeding child has lived and developed well. The mother reports her health much better than ever, though she thought herself well before, but now experiences much improvement in her capabilities, impressions, and enjoyment of all about her.

CASE II.—Mrs. E. related that her first and only child at this date (1882) was a girl, born with a cleft palate and harelip, and asked if the next child, should she have one, would have a like deformity. I replied that very likely it would, unless some change in her condition could be wrought by proper treatment, which might prevent it.

I gave her medicine and advised her to continue taking it until she became pregnant, of which she should then inform me. About three months after this she informed me that she was again pregnant, and requested if there was a possibility of a deformed child that I should cause an abortion. I gave her reasonable assurance of success if treatment given was continued, with such hygienic and dietetic means as were prescribed.

In due time the period of gestation was completed, the child born, and apparently perfect; upon observing which each (father and mother) gave an outburst to pent up feelings, showing the doubts that had existed in their minds

through the months of gestation, and that there could not be any of the success attributed to faith.

Shortly after that child was born I lost all observation of the family, until about one year ago, when I found the widow with one additional child, and was permitted to examine each of them. The two youngest each had a divided uvula; no other deformity apparent.

In the record of this case I found a history of dyscrasia, or diverted nutrition, in the cellulo-organic (morphological) processes, exhibited by the development in the mother's mother of an uterine fibroid, which I refer to as a possible exhibition of an error transmitted to her daughter, and ending in the deformity of her first child, but partially cured by the means used to prevent the error in her children.

The remedies used were calcaria c. 6x mornings, sulphur 6x evenings.

## SOME PROBLEMS IN THE CARE OF INFANTS.

BY

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**M**OST physicians appear to have arrived at the conclusion that cow's milk is the best substitute for breast milk. Many conclusions, however, when put to the test are disappointing, and this one is no exception to the rule. Many infants cannot digest cow's milk, and the cause may be found in just the difference which exists between cow's and human milk.

We are confronted with three problems which must be solved before milk becomes a proper food for infants. How to dispose of the acidity; how to dispose of the

extra amount of albuminoids; and how to dispose of bacteria.

The acidity of milk is due to fermentative changes which take place in it after having been drawn some time, milk being alkaline when taken from the cow. It is evident that the milk should reach the infant who is to live upon it before such changes have taken place. In cities, especially in warm weather, the problem is a difficult one to solve, in the country very easy; but it is the city baby who suffers the most from digestive disorders, and for whose benefit, chiefly, this problem must be solved.

It may be suggested, in the first place, that the udder and teats of the cow should be scrubbed before milking, also the hands of the milker, since it has been proven that milk remains sweet longer when this has been done. Furthermore, milk should be rapidly cooled after being drawn and then forwarded at once to its destination, so that those who use it as food may receive it within four or five hours. Where this cannot be done, and even as a general rule, it is advisable for milk, immediately after having been taken from the cow, to be immersed in ice water and kept cold until just before being used as food, when it may be warmed and prepared as desired.

This suggestion has reference to the future supply; at present the milk which reaches the consumer is slightly acid, and milk which is at all sour is entirely unfit for infant food.

The acidity, when slight, may be corrected by the use of lime water. This expedient while, perhaps, not theoretically proper, is often the best practical way out of the difficulty. Very little is needed, only enough to correct the acidity, which a trial with litmus paper will demonstrate. As lime is one of the ingredients of milk, this addition adds no new element to the food and has no evil effect upon the system.

The problem as to the management of the extra quan-

tity of albuminoids in cow's milk is by no means an easy one to solve, especially as it is complicated by the fact that the casein of cow's milk is precipitated in the stomach in large, tough masses, which are very difficult to digest.

It has been thought that an admixture of oatmeal gruel or some form of starch or infant food would cause the casein to be precipitated as a soft curd. The researches of Rotch, however, seem to disprove this; hot water and milk alone coagulated by acetic acid, forming a firmer curd than when either Mellin's Food, Robinson's Barley, Imperial Granum, cracker crumbs, or bread crumbs were added. Indeed, it would seem that the larger the proportion of starchy material added, the coarser was the curd.

In the course of these experiments it appeared further that, when acetic acid is added to human milk, no curd is perceptible. When added to raw cow's milk large curds are thrown down, and if cow's milk be boiled or sterilized by steam the curds are just as large. Boiling or steaming milk, therefore, does not appear to render the casein any easier to digest.

It is also found that when milk is mixed with water in the proportion of two parts of milk to one of water, the curd is slightly finer than that of raw milk. As the milk is diluted more and more and more the curd becomes finer, until, in the proportion of one of milk to five of water, there is no perceptible curd, or, in other words, the appearance is the same as that of breast milk.

It must then be concluded that in order to make the albuminoids of cow's milk as easily digestible by the infant stomach as human milk it must be diluted with water in the proportion of one to four or five. It is evident, however, that in thus diluting all the other ingredients of the milk are similarly diluted, and it becomes necessary to make up these ingredients to the full amount. Cream is therefore added to make good the loss in fat, lime water for the mineral loss, sufficient milk sugar, and we have now

a food closely resembling in all respects that provided for the infant by nature.

The following formula may be found useful :

Milk.....	2 ounces
Cream.....	4 "
Water.....	9 "
Sugar of milk.....	1 "
Lime water.....	1 "

Mix as soon as the milk is received and put on ice.

The third problem, how to render the bacteria in milk harmless, remains to be solved.

In searching for a solution to this question, one fact stands prominent. The milk which an infant nurses from the breast is sterile as to bacteria, passing from the breast of the mother to the stomach of the child. On the other hand, when cow's milk reaches the city home, it is several hours old and swarming with bacteria. A practical plan for rendering these minute forms of life harmless to the child is demanded, since investigation demonstrates that diarrheal disease is caused by their presence in milk. Boiling is an effective method, but is open to the objection that the taste is altered, as are, also, to a certain extent the chemical and mechanical relations of the milk elements. A better method, however, is to sterilize by means of steam. This may be easily performed, in the absence of a sterilizer, by pouring the food into feeding bottles, stopping the openings with raw cotton, and placing them in a colander, which is to be covered and placed over a tea kettle kept nearly full of boiling water. When the bottles are removed after twenty minutes, the bacteria will have been destroyed.

A point has now been reached where it may be said that by following the methods suggested three difficult problems in infant feeding have been solved and that we have at hand, in cow's milk, a food admirably adapted to those infants who cannot draw from the natural founts.

## NEUROSES OF CHILDHOOD.\*

BY

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**T**HE study of sanitary science and prophylactic treatment, to secure for the child perfect development and good health, is becoming popular. But he who runs may read that disease is marked upon the faces of the greater portion of the multitude; consequently every practitioner is busier curing the ills that exist than in teaching preventive methods. We are told by a recent writer that "Heredity accounts for the sameness of our race, the differences are the work of environment." We no longer inherit disease, but are born with a tendency to this or that malady, and our surroundings may produce an exciting cause for its development.

Of the morbid conditions demanding relief none are more important than the neuroses of childhood. These disturbances are numerous and varied, some arising from constitutional dyscrasias; others are induced by the climate, lack of care, temper of the attendants, or some unfavorable surroundings. Though we may not be able to suggest a cure-all for every case, it may be profitable to occasionally review the facts as we meet them.

Sometimes we recognize an irritation which is nerve wearing and gradually reduces the vitality, and again it is a form of well-marked disease. Among the latter claiming our attention is coryza of infants. An able authority says: "This flow, more or less profuse from the mucous membrane of the nasal cavity, once considered temporary and an unimportant affection, to-day is recognized as an alarm

\* Read before the Pennsylvania State Homeopathic Medical Society, September, 1893.

note indicating the approach or existence of serious trouble. This may be the initial symptom of zymotic affections or the earliest manifestation of impaired nutrition. The membrane lining the nasal cavity is so sensitive to nervous impressions that irritation there may cause asthma, epilepsy, chorea, hay fever, and other forms of neurosis. A case is reported where coryza appeared, followed by sneezing and then spasm of the throat, proving fatal. The laryngismus was beyond control, but the early treatment of the coryza might have ended the morbid tendency.

Since we know the nervous character of this affection, and know that such measures and remedies as restore strength and health of nerves bring most permanent relief from this condition, we are strengthened in our resources against future attacks of each individual case.

This age of progress and invention has given us rapid transit by means of cable and electric cars. They traverse every prominent street and some alleys in not only cities and towns, but the village and hamlet as yet not honored with a charter of incorporation. The noisy revolution of their wheels and clanging of bells have disturbed the children's sleep and made the necessary quiet and rest impossible. I am certain this influence is a positive injury to many children, yet I am unable to remove the cause, and often doubt that any remedial measures will modify or cure the irritation thus produced of those highly sensitive systems. To expect medicines to strengthen their nerves is like holding your hand in the fire and demanding relief from its effect.

It may be a useless reference, but I venture to mention that the use of stimulants and tobacco by parents bankrupts the nervous force and energy of their descendants. Many thus begin life with unhealthy nerves. In the nursery they are roughly handled, tossed, and jolted about; kept in a constant state of excitement during waking hours; and if they survive long enough to reach school there meet influ-

ences which rapidly develop chorea or some graver form of disease. A school-teacher of large experience recently stated that under his observation the school routine had a worse effect upon boys than girls. They seemed more restless under the pressure of long hours, poor ventilation, and little exercise ; and more likely to fall victims of acute disease appearing in epidemic form. It is an everyday observation of any general practitioner that many girls suffer from chorea, neurasthenia, or nervous headaches before reaching puberty ; the cause thereof may be traced to heredity and environment combined. While we recognize and battle to remove suffering induced by the above influences, we would not forget that important condition generally mentioned first of the nervous disturbances, viz., convulsions. They are always alarming, and frequently fatal. They may be induced by an ebullition of anger on the part of the nursing mother or by shock or fright from the conduct of a cruel, drunken father. They may occur as the first evidence of exanthematous disease or from the pressure and injury during a difficult and instrumental delivery.

I am here reminded that the recent demonstrations of Kischensky, Wissen, and Beumer teach us that trismus and tetanus of the newborn may no longer be looked upon as a neurosis, but must be regarded as a traumatic infection ; that convulsions, whatever the cause, occur more than twice as frequently during the first year as in any period later up to twenty years. This is due to the difference in the nervous systems of the infant and adult.

In infancy the higher brain is imperfectly formed, while the lower cerebral centers are more fully developed ; as a consequence an irregular outbreak of nervous energy is the result. Causes which in an adult will merely produce a chill may be sufficient to bring on a convulsion in an infant. Hence the importance of not only restoring a tranquil state of the nerves of that child, but if possible giving him



resistive power against a future demand. The sudden call at the time of attack often affords no opportunity of administering curative measures. But if permitted to be medical counselor, having observation of and acquaintance with the patient for any considerable time, the follower of Hahnemann may hope to fortify the system with such strength that it will resist future spasmodic action. If possible for the patient to secure air, water, and food of pure quality, the cure will be greatly hastened.

Then by delving among the records of drug provings, or, if necessary, instituting new provings, learn the similia of the diseased condition. Of course it will take diligent study before one can readily know what to give the case as presented. But you will be likely to secure sleep for the excitable, restless, wakeful child from the use of remedies having these symptoms prominent as keynotes in their provings.

Many nervous children are soothed for the time, and finally made strong, by the continued use of coca—not the wine, but in the potentized form. I have had good results from the 3x up. The remedies usually restoring spasmodic action are well known to you all, but I wish to emphasize the importance of studying the tissue remedies. I have known chorea from eye strain to be cured by mag. phos. and kali phos. Neurasthenia and eclampsia are also markedly benefited by their use. The continued use of some remedy, when the child is considered only nervous, may prevent a future interesting case of mental alienation.

## ENTEROCOLITIS.

BY

JULIA C. JUMP, M. D.

OBERLIN, O.

**D**IARRHEAL diseases are prevalent among children during the summer months, especially those who are under  $2\frac{1}{2}$  years of age. The attack may vary from a slight disturbance of the system owing to a chill, or to indigestion, to a severe or even fatal attack of inflammation of the lining membranes of the intestines. In enterocolitis we have an inflammation of the lining membrane of the small intestines and the colon; hence the name.

***Ætiology.***—The causes of enterocolitis are atmospheric and dietetic.

Dentition is also a common cause of the disease. Enterocolitis is most prevalent and most fatal during the months of July and August. Hot, damp, foul air and filthy surroundings will generate the disease. Children living in the city suffer more than those in the country from the lack of pure air and proper food.

A bottle-fed babe is seldom able to rally from a severe attack. It is almost impossible to secure milk that is suitable food for a babe in the city. There are many prepared foods for infants, of more or less merit, but it is difficult to find one adapted to the wants of a sick babe.

All mothers dread the second summer for their little ones, knowing that the system is more or less disordered by the process of dentition, and that they are liable to diarrheal diseases.

***Symptoms.***—The attack usually begins with a slight fever, restlessness, and debility. At first the diarrhea is slight. The stools are thinner and more frequent than usual, and vary in color, being yellow, brown, or green, and

sometimes almost white. They may be watery. If the child is fed on milk there may be particles of undigested curd in the stools. The tongue is usually covered with a slight fur, and is moist at the beginning of the attack. Later it is often dry, and the buccal cavity very red. Nausea and vomiting are common symptoms, and may appear early in the attack, though usually they do not occur till the end of the first week. If the attack begins with vomiting, there is some offending substance in the stomach which the system is trying to reject. When the vomiting occurs at a late stage of the disease, it is usually due to spurious hydrocephalus.

As the disease progresses, the stools may vary in color and consistence. From being yellow, brown, or green at first, they may change their character so as to contain little or no fecal matter, and consist almost entirely of mucus, with perhaps a trace of blood. The odor is sometimes very fetid, while at others it is decomposed. The pulse varies with the severity of the attack. In fatal cases it increases in frequency, growing more feeble toward the last.

The thirst is usually intense, and the child will take the breast with avidity to satisfy its craving. The urine is usually scant, and voided at long intervals. The skin is hot and dry, except in fatal cases, when it becomes cool and moist.

In protracted cases we often have erythema of the lower part of the body, and sometimes a succession of boils on the different parts of the surface.

*Pathology.*—*Post-mortem* cases of enterocolitis show an inflamed condition of the mucous membrane of the small intestines and of the colon. The vermiform appendix is sometimes involved. The inflammation of the colon is most severe in the region of the sigmoid flexure, and of the small intestines in the lower part of the ileum, involving the ileo-cæcal valve. The discharges being acid and corrosive, the inflammation is most severe where the mass is

most delayed. Payer's patches and the solitary glands are inflamed. The glands are found in some cases tumefied, in others, ulcerated, while some of the glands are entirely destroyed. The inflammation extends from the ulcerated gland to the surrounding membrane.

Small round or oval ulcers are found in the mucous membrane of the small intestines and the colon.

*Prognosis.*—The prognosis in severe cases is grave. It will depend on the vitality of the babe, the character of its food, and the sanitary condition of its surroundings, as well as upon the heat of summer.

The disease is most fatal in very hot weather, and more fatal in bottle-fed babes than in those nourished at the breast. It is far more fatal to children living in the city than to those living in the country.

The ravages of this disease are much greater among the poor in the thickly settled portions of a city than where the grounds are spacious and the air pure. Cleanliness, pure air, and sunshine are important factors in the treatment of enterocolitis.

This disease seldom proves fatal in a babe living in a healthy locality in the country, especially if the child is nourished at the breast.

The treatment of enterocolitis should be hygienic, dietetic, and therapeutic. See that the environments of the babe are in a perfect sanitary condition. The success in the treatment of the case will in a great measure depend on the cleanliness of the child, its clothing, and surroundings. The mother or nurse should be scrupulously clean in person and dress. The bed should consist of a light mattress, which, with the bedding, should be clean. It should be aired once or twice daily. Especial care should be taken of the vessels in which the milk is kept in case the child is fed on milk. The bottles and nipple should be thoroughly cleansed, then scalded with water containing a little soda. Let them remain in this water till cold, then

rinse with water which has been boiled. Let them remain in the last water till just before needed; then drain carefully before filling the bottle. Prepare just food enough for one meal at a time, and if any remains after feeding throw it away and again cleanse the bottle.

No decaying vegetable matter should be allowed on the premises. Keep the babe cool, but let it wear a band of soft flannel around the abdomen.

If the babe is nourished at the breast, the mother or nurse should be careful of her diet, and should always rest, if weary and warm, before nursing the child.

*Dietetics.*—The mother's milk is best, as a rule, for a babe's food. If bottle-fed, the problem of food which confronts one in the city is a serious one. Milk, sterilized on the farm where it is produced, if drawn from healthy cows, would be a safe food.

The cows should be selected with the greatest care, should have good pasture and pure running water. The milk should be drawn in a clean place, where the air is pure, and should be sterilized as soon as drawn. All vessels used in handling it should be scrupulously clean. Milk brought to the city is too old, when it reaches the consumer, to be a suitable food for a babe.

Fermentative changes have already begun. Good cow's milk is the best substitute for mother's milk. It should be the milk of one cow, selected with great care, the milk being no older than the babe. It may be younger. If sugar is added, it should be the sugar of milk, and only a very small amount should be used. Many of the prepared foods on the market are good, and by careful trial one may be found that will suit the case.

Food which suits one child may disagree with another.

Mellin's Food, Lacto Preparata, Malted Milk, and many other brands have given me good results.

Condensed milk is sometimes well suited to the digestion of the babe.

The "Flour Ball" is very useful in severe cases, prepared as follows :

Flour, one pound ; salt one teaspoonful ; sugar of milk, one teaspoonful ; cold water four tablespoonfuls. Mix well, tie tightly in a strong muslin cloth so as to form a firm ball. Boil in a kettle of water twelve hours. Drain it dry. When cold remove the outer covering of paste, and the inner part will be found to be dry and hard. Keep dry ; when needed grate off two or three tablespoonfuls, mix smoothly with a little cold milk, then stir it into a pint of hot milk. Do not let it boil. This recipe has probably saved many lives.

The pulp of raw lean beef is very nutritious. Cut a piece of nice lean beef across the grain, then scrape the pulp from the fiber, using a silver spoon, then cut off a slice, and scrape again, until a sufficient amount is obtained. Add a little salt, and feed to the babe.

Albumen water is useful in severe cases. Stir the white of an egg with half of a pint of cold water till it mingles. The child will drink this when thirsty. If desired, add half of a teaspoonful of sugar of milk. For the country babe, good milk may be obtained.

When practicable, have it drawn fresh from the cow for every meal. When this is not convenient, get fresh milk night and morning. Keep in clean vessels in a cool place, where the air is pure.

Prepare just enough at a time for one meal. Warm it to blood heat, and, if desired, add a very small quantity of sugar of milk.

Should any remain in the bottle after feeding, throw it away and cleanse the bottle.

A babe should have all the cool water which it craves. Give it at the temperature of the atmosphere, not ice cold. Feed the babe at intervals of two or three hours. Do not give it the bottle or breast because it worries during the interval between its meals. Remember that milk is food, and does not quench the thirst of the babe.

Only pure water should be used. When the wells and springs are low, in dry weather, all water should be boiled for drinking purposes. A fretful, feverish babe many times may be soothed by a good drink of water, so that it will go to sleep, and during the sweet sleep perspiration will cover the surface, so recently dry and feverish. Try it.

*Therapeutics.*—Study the *materia medica* carefully for each case.

Acon., æthusa, apis, ars., bell., calc. c., calc. phos., carbo. v., cham., china, cina., coloc., croton tig., dulc., graph., ipec., nux v., phos., podo., rheum, sul., and veratrum are some of the leading remedies for enterocolitis. Individualize each case with the greatest care.

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## THE NEUROSES OF CHILDHOOD.\*

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BY

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IN thinking over how I might best respond to the wishes of those who were the originators of efforts at regular teaching in connection with this hospital, I decided to abandon the subject at first announced, interesting and fruitful from a student's point of view though diseases of the spinal cord always are. To meet the responsibility placed upon me by the kindness of my colleagues, I felt that I ought to choose a subject where medicinal treatment, and of course homeo-therapeutics, play an important and useful part. It seemed to me that both on this ground and on that of one's familiarity with the subject, owing to their constant presence in our midst, "The Neu-

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roses of Childhood " might profitably occupy our attention for an hour to-night.

Under this heading I propose to ask your kind consideration of a few conditions, most of which we are all liable to be called upon every day to treat. They are convulsions, chorea, tetany, and head-nodding.

And first as to

*Convulsions.*—I propose to make my discourse a therapeutical one throughout. Any allusion to ætiology or to symptoms and course of diseases will only be made in order to facilitate the study of the treatment. One of the first questions which presents itself to a beginner in the study of homeopathy is, "Can the new system do anything, with its small doses, for cases requiring prompt measures and quick, decided results?" Such measures and such results are imperatively demanded in a case of convulsions. What can we do? Here more than in most cases we should bear in mind that injunction of first importance, *tolle causam*. Let us briefly ask, "What are these causes?" Firstly, the predisposing causes may be enumerated as rickets, anæmia, weakening conditions, and hereditary tendencies. Next the exciting causes: these are mainly reflex. In infancy and early childhood reflex action is much more prompt and complete than in later years, and, owing to the absence of the controlling influence of the highest centers (then largely undeveloped) the afferent impulse spreads readily to adjacent cells, producing widespread and violent reflex response—in other words, convulsions. The afferent or exciting impulses vary indefinitely; a loud sound, a painful operation, unsuitable food or foreign bodies in the intestinal canal, or disease affecting the same part, teething, respiratory troubles, high temperature due to the above named or other causes, a poison in the blood, inflammatory irritation of almost any peripheral part or tissue. Some of these causes may gradually or at once permit of removal by means with which you all are or may become familiar.



Our inquiry deals rather with the treatment of fully established eclampsia, where the cause is either no longer operating or not at once capable of removal. Baths, aperients, and sedatives, such as bromides, chloral, and chloroform, constitute the chief armamentarium of the old school. Can we add to or improve upon these? The baths, in suitable cases we of course agree with; occasionally also, where we believe a mechanical irritant to exist in the bowels, we might also use a purgative. The sedatives we should postpone until more specific medicines had either failed or rendered their use unnecessary. The most frequent exciting cause of infantile convulsions is dentition, attended or not with pyrexia, and the most frequently used remedy is belladonna. The flushed face, elevated temperature, rapid bounding pulse, dry, hot skin, excited, frightened manner, starting or twitching of muscles preceding general convulsions, are exactly paralleled in belladonna poisoning; not less so are the fully developed convulsions. In such cases the rapidly soothing effect of frequently repeated doses of belladonna, in almost any dilution, is most gratifying, and leaves nothing to be desired.

In other cases pyrexia is absent or is only developed during the progress of the fits. This may happen in intestinal irritation, especially if the child is reduced by diarrhea or ill-feeding. Here the well-known convulsive action of hydrocyanic acid comes in. In small frequent doses it rapidly acts "substitutively," as Trousseau calls it, neutralizing the fits by occupying their own area with a *similar* but different influence.

If gastro-intestinal irritation—not mechanical but inflammatory—exists, and painful tonic and clonic spasms are wearing out the child, copper, either the triturated metal or the acetate, will give prompt and lasting relief. For fits associated with whooping cough, too, this remedy is without equal.

Another remedy for convulsions, especially if the cause of them is not apparent, is cicuta, or its alkaloid cicutine, which I prefer. For the description of a case of poisoning by this substance I refer you to a report by Dr. Stonham in the *Monthly Homeopathic Review*, and I cannot do better than read to you, in illustration of its action, a cure published by the same writer (see pp. 225-27, April, 1893).

Of the value and homeopathicity of cina in cases of convulsions there is abundant testimony. It is usually thought of where worms are present, and although the medical profession nowadays attaches less importance to the presence of these parasites than it formerly did and than the laity now attaches to them, there should be little doubt that either their presence or the existence of a condition favoring their growth, does act prejudicially on the health, and may even excite convulsions. Dr. Hughes gives the following statement of the effects of the drug, which will serve as indications for our administration of it:

“There are the dilated pupils, with dimness of the sight and twitching of the eyelids, the ravenous appetite, the pinchings in the abdomen, the itching at the nose and anus, the frequent micturition, the spasmodic cough with vomiting, the restless sleep, the fever and the twitchings in various parts of the body.”

Gelsemium is a remedy which is extremely useful in the condition of semi-stupor which frequently follows an attack of convulsions. The patient cries when roused, as if in pain, soon relapses into drowsiness, avoids the light and keeps its head pressed against its mother, readily starts at a slight noise or movement. There are either cramps or twitchings of the limbs.

For the convulsions due to pneumonia or the exanthemata, we shall do more good by taking into consideration the whole condition, and not treating the convulsions only, though it must be remembered that even here belladonna may be of great use. The same is true of convul-

sions due to meningitis, though if the disease be of the tuberculous variety, we may not delude ourselves with ungrounded hopes.

*Chorea*.—It is unnecessary for me to detain you upon the varieties, symptoms, course, and prognosis of chorea. To facilitate the study from a therapeutic point of view, I shall ask you to divide up cases of the St. Vitus' dance into the following classes:

1. The first I shall call *simple* cases. The purposeless movements common to all classes are, of course, present. They are not peculiar either in their severity or in their localization, being of moderate degree and more or less general in distribution.

- 2 and 3. The second and third classes own either fright or traumatism as an exciting cause.

4. The fourth may be called rheumatic from their more or less definite association with that disorder.

5. The fifth may be styled mental cases on account of the presence of some peculiarity, more or less pronounced, of the state of the mind. The patient may be "hysterical," or may be suffering with mental hebetude or even with insanity, maniacal or idiotic.

Now I readily grant that this classification is rough and imperfect, and that the different classes may either overlap or merge into one another. Nevertheless, I believe that imperfect as it is, it will materially help us in making suggestions as to the treatment, unless indeed I am to content myself with Hahnemann's laconic, but comprehensive advice, "study the materia medica." It is so easy and so brief a command, and would refer equally well to the drug treatment of any and every disease, that it would render, were nothing more required, a course of post-graduate lecture, such as I bring to a close to-night, entirely unnecessary. What we wish to know, if I am not mistaken, is, "What has the study of the materia medica already yielded, which will be of practical value to us in the treatment of a given

disease?" We require the results of experience, even at the risk of a certain amount of empiricism.

Before entering upon the discussion of the drugs commonly used in chorea, let me remind you that, up to the present, the pathology of this disorder is involved in obscurity. English authorities, rejecting the spinal theory, mostly regard it as of cerebral origin, due to a lesion either of the corpora striata or of the motor area of the cortex—a "discharging lesion." This uncertainty makes it impracticable to select medicinal remedies on the pathological basis, and affords an excellent illustration of the applicability of the rule of similars to cases the nature of which is still imperfectly understood.

Let us now turn to the drugs themselves.

Our first division we termed *simple* cases. To these we confidently oppose arsenic, and in this, as you know, we are at one with empirical medicine. If there are loss of appetite and flesh, coldness or feeble circulation, and vomiting with clean tongue and anæmia, arsenic will be additionally indicated. With the use and the utility of this drug you are all familiar. It only remains for us to see if there are any grounds for claiming this practice as homeopathic. It should be remembered that we are unacquainted with *any* drug which produces an illness entirely similar in character, distribution, and course to chorea. Indeed as no two cases of chorea resemble each other in all these points, were such a similarity necessary, we should require a different drug for almost every case of chorea. It is sufficient that the drug be working on the same tracts or lines, so to speak, and in a manner similar if not precisely alike. The chorea producing agent "lowers and disturbs" some parts of the nervous system—so does arsenic. They both alike produce nervousness, fidgeting, and restlessness; they both produce muscular movements of more or less irregular type and amounting sometimes (often in the case of chorea, seldom in the case of arsenic) to clonic spasms. Lessened

muscular power also is produced by both. Acting in the same area, these two forces neutralize each other when opposed. Experience has shown that neither the attenuated doses of some of the followers of Hahnemann, nor the substantial doses of other practitioners, are necessary to insure neutralization. In cases of long standing of almost any variety, *ars.* or *ars. iod.* forms a valuable inter-current.

The second and third classes, where fright or injury is clearly marked, call respectively for *aconite*, *ignatia*, *argent. nit.*, or *calcareo carbonica* and *hypericum* or *arnica*. The *aconite* is suitable only for immediate use; *ignatia* is required also in recent cases if the movements are pronounced and active, if the changeable or sighing and weeping disposition with love of solitude are present, and especially if the symptoms are left-sided. The *calcareo* patient is weary and phlegmatic. The muscular movements have a tendency to be one-sided, and *calcareo* affords an example of the symptoms being present on opposite sides in the upper and lower extremities. Here chiefly the left upper and right lower limbs present muscular movements. With respect to this symptom clinically, I am bound to confess that in my experience this peculiar grouping is quite exceptional. Still, with a malady so varied and multiform as chorea, in its manifestations, it is impossible to state that such opposite-sided involvement may not occur. When present, *calcareo*, if the condition of the patient corresponded in other respects, would be additionally indicated.

Weariness and exhaustion, associated with melancholia, dislike for solitude, flatulent dyspepsia, with aggravation of the whole condition after eating, call for *argent. nit.* In the pathogenesis of this drug, chorea-like movements are included, and its power to produce convulsive movements is well known.

The relationship of *hypericum* to cases of chorea induced

by injury, is mainly an empirical one. That of *arnica* is strictly homeopathic. Muscular movements, feeling of fatigue, aching or bruised sensation, common in severe cases of chorea, are all represented in the *arnica* pathogenesis.

The fourth form—the rheumatic variety—consisting of by far the largest number of cases, may be related to that condition either as a sequel of a rheumatic attack of more or less severe character, or as presenting joint or muscle pains at the same time as the movements of the limbs. In either case one leading medicine is at our disposal; I refer to *actæa racemosa*, otherwise called *cimicifuga*. As a remedy it needs no commendation from me, and it is only necessary that I should point out its homeopathicity to the condition before us. The power of the drug to irritate the nervous and muscular systems, and to cause muscular spasms and tremor, at once brings it into relationship more or less accurate with chorea. The drawing, aching, bruised, or rheumatoid pain in upper or lower extremities, in back and in the eyeballs, palpitations, excited cardiac action, or the presence of a murmur—such pronounced features in the provings and poisonings with this drug furnish an admirable picture of the rheumatic element. To these we must add the restlessness and nervousness on the one hand and the dejection and muscular weakness on the other, and its applicability to a large class of cases becomes evident. Not infrequently the drug symptoms are more marked on the left side. Left-sided hemichorea will thus be a condition for which we should consider the suitability of *actæa*. *Actæa* corresponds both with a depressed anxious mental state, and with one in which irritability is prominent. In severe cases mild delirium with illusions may be present, *i. e.*, both in the natural disease and the drug. Finally, the interference with articulation may be matched in this drug. That it should be widely used, on the principle of similars, is therefore in nowise surprising.

Fifth. The cases I have styled mental cases, where disturbances of mind are conspicuous may, as already hinted, require actæa; restlessness, nervousness, fear of death, delirium suggestive of delirium tremens, apprehensiveness with sighing, alternation of depression of spirits with exhilaration would indicate that drug. For hysterical symptoms *ignatia* is specially and quickly helpful. For cases more pronouncedly mental, with much delirium, amounting even to a maniacal condition, in addition to belladonna and hyoscyamus, I wish to commend specially stramonium. The excitability and irritability amounting even to violence are very great; fear and *suspicion* are conspicuous, the nights are much disturbed, food is refused and speedy exhaustion from loss of nerve and physical force ensues. The movements in this case also may occur crosswise, one leg and the opposite arm be affected while the rest of the body is comparatively unaffected.

For cases where mental heaviness, difficult or slow comprehension, forgetfulness of messages, dullness, general backwardness, bashfulness, difficult or thick articulation—where these form the chief symptoms and the movements are slight and confined perhaps to the hands and face, I have learned to have much confidence in calc. phosph. The patients are pale, thin, badly nourished children, such as we commonly meet in the out-patient departments of our hospitals.

You will expect to hear something of agaricus, which perhaps deserved mention earlier. Its pathogenesis presents—as far as the muscular movements are concerned—one of the most perfect pictures of chorea we have in any drug. In idiopathic cases where the movements are well marked, where no other features are prominent, we may use agaricus. Though I have often used this drug, I have not met with any very convincing results, and I try to place my case under one of the afore-named classes or seek for symptoms other than the movements as guides. If

I am unable to do either of these, agaricus comes in usefully.

In contrast to agaricus, which I consider an overlauded remedy, allow me to draw attention to belladonna, of which I entertain a high opinion in this disease. It is only necessary to observe a few cases of bell. or atropine poisoning to be struck with the resemblance some of their features have to chorea. Flushing of face, full headache, and restless, dreamy, wakeful sleep call for this remedy. It may occasionally be advantageous to arrest the more specific treatment of the movements, and to pay attention to the digestion, which is apt to be deranged; here nux v. or sulphur may be beneficial.

Another group of remedies probably deserves attention and certainly requires to be mentioned here, for the sake of completeness, although I cannot commend them to you from personal experience. I allude to the poisons of several of the spiders, specially the mygales and the tarantulas. Analogous in their origin and effects to the serpent poisons, they have an effect all their own on the nervous system, which persists when the local conditions due to the bite have passed off. Excitability, muscular twitchings, hands constantly in motion, aggravation from lively music and from observation, inability to sleep, these are symptoms produced by the spider poisons and likely to be relieved by the same agents. These poisons will probably repay study, as will also the last medicine I shall mention, viz., cuprum, useful especially with spasmodic movements and anæmia. This drug is being used in the old school.

Though, in considering the management of chorea, I have hitherto alluded only to the medicinal treatment, it is not because we of the homeopathic school consider drugs as the only important—or even the most important—agents to be used. When carefully selected their usefulness is unquestionable. General hygienic measures are common ground to all careful practitioners of medicine, and I only



refer to them to remind you that while placing more confidence in drugs than do our old-school friends, we value very highly general measures. Of these I will only mention complete rest at first, combined with a very nourishing but easily digested diet. At a later stage efforts of will, regulated gymnastics, rhythmical movements, especially when accompanied by music, are of the highest importance. Massage also is useful.

Chorea is a disease of depression; everything must be done to lessen and repair tissue waste. Sleep must be obtained by some means, and high feeding is one of the most important means for this purpose.

In anæmic cases we should give *iron* as a tissue-food, as do all schools. This in no way prevents or interferes with medicinal treatment.

One important point I may mention before leaving the subject—that sedatives and narcotics are but seldom needed during the treatment of chorea on homeopathic principles. In one case only of those I have already referred to as treated in this hospital did I find that a sedative had been used. I must here express my indebtedness to my colleagues for very kindly allowing me to consult their case books.

Lest it should be said that the many drugs I have mentioned serve to confuse rather than to give a practical idea of the most successful treatment of chorea I will briefly state my own experience and that of others. I should rank together *actæa* and *belladonna* as the two most useful medicines; after these I should put together *arsenic* and *copper*. Finally, though I have no experience with those agents, I should speak very favorably of the spider poisons. In this hospital the favorite medicines—which rank far above all the others—are *arsenic* and *actæa*. Of sixty prescriptions which I examined sixteen were of *actæa* and seventeen of *arsenic*. More recently *mygale* and *tarantula* have been occasionally given with decidedly good results.

I need scarcely remind you that there is really no question of rival remedies for chorea, but of what remedy is most suitable for any given case. This can only be determined by the symptoms present, especially by those relating for example to the mental state or the digestion, etc., rather than by the movements present. Every drug useful in chorea should show a power of disturbing the balance of the motor centers to a greater or less extent. Hence it is to symptoms or signs outside strictly choreic manifestations that we must look as guides in the selection of our remedies.

*Tetany.*—Arising as it does from a variety of causes this condition is in many ways analogous to convulsions, and many of the remarks regarding them are true of tetany. The spasms are, however, tonic rather than clonic. So obvious is the relation of strychnine to this condition that it seems superfluous to dwell upon it. Where anything is required beyond the constitutional measures used for combating the disease at the bottom of this state, strychnine will do all that is required. Where exposure to cold has been the exciting cause, rapid resolution will be brought about by the use of aconite.

*Head-nodding.*—This curious and unexplained neurosis, on which I wrote a paper in the first volume of the *London Homeopathic Hospital Reports* (1891) has, unfortunately, not proved very amenable to treatment hitherto. In addition to the suggestions made in that paper, I draw attention to agaricus as likely to be useful for the shaking variety (movement of dissent).

Respecting the treatment of this interesting condition I cannot do better than quote my remarks in the paper alluded to. Since that was written there is little or nothing to add. "The treatment hitherto pursued has been either by means of general sedatives or by tonics so-called. Of the first, bromide of potassium has appeared to be of use, and in my own patient and that of Mr. Knox Shaw, belladonna was given with possible benefit. The belladonna may

have a more specific relationship with the condition than that of a general sedative. 'Allen's Handbook' gives 'Head thrown hither and thither even to shaking, then again convulsive bending forward of head and trunk.' (Salaam convulsion?) According to the same authority the spasmodic eye symptoms are limited to 'squinting' and 'spasms.' Other general anti-spasmodic remedies would readily suggest themselves—ignatia, strychnia, etc.

"In connection with teething, chamomilla, our sheet anchor, may probably be of service. Besides its general convulsive action, the symptoms, 'wagging backward and forward' of head points to its employment.

"The symptoms of both head and eye are perhaps better portrayed in the pathogenesis of agaricus than of any other drug. 'Swaying back and forth' of head; 'convulsions of muscles of head and neck' (Allen). No matter whether they are fixed upon an object or not, 'the two eyeballs revolved to the right and left with a velocity of half a second, and this continued all day.' 'Reads with difficulty, type seems to move.' 'Trembling and jerking of eyelids' (Hering). In several of the cases of poisoning recorded in the Cyclopedia of Drug Pathogenesis, among the convulsive symptoms, the eyeballs are said to have 'rolled' about. A condition apparently resembling 'hippus' (produced by muscarin) is described under the term 'accommodation convulsions.' Although in none of these cases an exact imitation of nystagmus is produced, yet it is evident that considerable disturbances to the ocular motor centers took place. Two cases of nystagmus are recorded in the January number (1891) of the *Jnl. of Ophthalmol., Otol., and Laryngol.*, in which the continued use of tincture of agaricus appeared to act curatively. Under cicuta 'head jerking' and 'objects seen to move from side to side' and 'in a circle.'

"Rachitis is not frequently associated with 'head-nodding and nystagmus,' but such association to be present

would suggest silica, and the usefulness of that drug in some excitable conditions of the nervous system would confirm the choice."

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REPORT ON ORIFICIAL SURGERY BASED ON  
ANALYSES OF ONE THOUSAND CASES, READ  
AT THE HOMEOPATHIC MEDICAL CONGRESS.

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BY

CHESTER G. HIGBEE, M. D.,

ST. PAUL, MINN.

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THE author of the review with the above title recently said, "An article, when it is given to the profession, becomes the property of the public and is justly open to criticism and condemnation if founded in error, or adoption if approved by experience and practical application." As this report was read just before midnight when many of the doctors had been busy ten or twelve hours, the subject matter or the author's conclusions were passed with but little consideration. This surely was not because the subject was unimportant or the presentation unmagnetic. We believe if the so-called principles therein promulgated are of such unusual application and as curative as the author asserts the fact should be generally known. We believe also that if there is more fancy than philosophy in the theory, and that patients are subjected to unnecessary operations endangering their lives and mutilating their bodies, this too should be known to the profession. As the paper has been published and commented upon by personal adherents of the author, will it not be well to consider in detail the report and draw our own conclusions?

The author applies the theory to so-called incurable diseases, but in practice, as illustrated in the detailed report,

he treats hundreds of cases which every homeopathic physician ought to know are curable by other treatment and without the use of the knife or any other serious operation. Suppose some patients do make what seems to them an almost miraculous recovery. All physicians have similar cases under different forms of treatment, but they do not make a practice of publishing such cases and citing them as evidence that the special form of treatment used in that case establishes a principle in practice.

When the author makes the assertion that "always and without exception under such circumstances upon examination will there be found pathological conditions at the lower openings of the body sufficient to account for the lowered vitality which alone could explain prolonged pathology," his experience certainly does not accord with that of any considerable number of educated homeopathic physicians and is not our own, for we have examined hundreds of cases expecting, from the theory, to find disease at the lower orifices, and after the closest scrutiny could find nothing of the kind. It is well said that specialists find what they are looking for. Many times in consultation with so-called official surgeons we have demonstrated that the supposed pathological condition was nothing more than an exaggerated growth of healthy tissue. In an elongated prepuce we have an example of abnormal growth without pathology. To be sure, a strictured prepuce may *cause* pathological conditions, but thousands of cases never have any such conditions. How absurd to say that the Jewish rite should be applied to all cases because one in thousands needs it.

We fully agree with the author's third proposition "that greater care must be exercised in its employment, or its methods must be so improved as to add to its efficiency as a remedial agency and deprive it of its power for harm." It does not seem to have occurred to him that there was any *inconsistency* in assuring us that his measures will cure

conditions caused by "anæsthesia or hyperæsthesia," and by contraction or dilatation. Is it reasonable to suppose that Nature has so changed her process of repair that even with our reporter's assistance she cures acne and eczema in a *few days*? He very considerably says that in "nasal catarrh and hay fever some form of local treatment may be necessary to complete the cure."

We will not enumerate all the minor diseases to which he says he has applied the treatment and which are so readily curable by other means. It will also need other evidence than that contained in this report to convince the average physician that organic diseases such as spinal sclerosis, Bright's disease, diabetes, or phthisis pulmonalis can be cured by his method.

As we see by the list of fatal cases that he made several mistakes in diagnosis, it is fair to suppose that he may have been mistaken in some others which he reports as cured.

In examining the list of cases given we have figured that more than seven hundred useless operations were performed. We say "useless," for in our experience and from the knowledge of the cases gained from the report we believe they could have been cured without an operation. Others are reported as no better from the operation. Scores and we believe hundreds of physicians will bear witness that with the proper use of electricity, without other means, better results could have been obtained in the cases cited. Electricity will do all that the author claims for many of his operations. It will instantly flush the capillaries, and the dose can be regulated to get the desired effect without subjecting the patient to the possibility of injury. We would not overlook the fact that these cases had been under treatment for a longer or shorter period of time, and of all forms of treatment, including electricity.

If the other treatment had not been more intelligently

applied than the so-called electrical treatment as used by physicians in general we do not wonder that these cases were considered incurable. In speaking apologetically for the many failures the author says: "In such cases this condition is either the result of unfinished work or of poor work, and of course should be charged to these accounts rather than reported as arguments against the philosophy." He further writes: "It is quite common, however, for three, six, nine, and even twelve months or *longer* to elapse before satisfactory reaction takes place, even in cases which finally recover as a result of the work." How many of the cases are ever heard from "three, six, or twelve months or more" after they have gone through this operating mill? How does the author know that there was final recovery or what evidence has he that it *is* the "result of the work"? These are pertinent questions that apply to a large number of the cases reported. What shall we say of one who will operate (and take large fees for the same) upon forty-three cases of cancer, and even with his fertile imagination cannot report the least benefit to the patients?

We now review the report of the fatal cases. Of the female cases the first was clearly a case of too much surgery. A delicate, chlorotic woman is subjected to the so-called "American operation." Her uterus is scraped and packed and still she survives until a second scraping and packing produces cellulitis and death.

The third and sixth cases show an inexcusable mistake in diagnosis, when it is probable that, if the true condition had been recognized and only the necessary operation performed, the patients would have recovered. It is beyond comprehension how a physician of the author's intelligence and experience can be so prejudiced or blinded by his one idea of rectal pathology that he could overlook these cases of pyo-salpinx or ovarian abscess that are curable and perform useless and uncalled-for operations, resulting fatally.

The fourth case was no doubt the result of too much surgery, for there is nothing in the case as he describes it that need endanger life.

The fifth case was one of mental depression and spinal irritation. Uterine scraping and packing and rectal dilatation and *death* from *septicæmia*. Of course the septicæmia was the direct result of the useless scraping and packing.

The seventh case is one that might prove fatal from any operation under an anæsthetic. We think it probably a case needing careful preliminary treatment and an operation for laceration without the meddlesome rectal operation or dilatation.

The eighth case, chlorosis and a mild form of hysteria : Operation for laceration of the cervix, *rectal* dilatation, and death.

What shall we say of the fatal cases among the men ? We do not know any possible excuse or justification for such an operation in either of these cases. According to the best judgment of all our best authorities there was no possibility of obtaining even relief by such an operation, and there was every probability that it would prove fatal.

In conclusion, we wish to say that we have for many years had a pleasant, personal, and professional acquaintance with the author of the paper, and no one glories more than we in his American push and enterprise. How he could present this paper as a scientific explanation and verification of his theories passes the comprehension of many of his friends. By later reports we learn that those women who survive his rectal operations are now being subjected to a new operation for removal of the uterus. We fear that an operation which is undoubtedly a valuable addition to our surgical methods may be prostituted to the craze to operate and many needless operations of this kind be performed.



## A PROLAPSED INVERTED UTERUS.

BY

EDWIN DE BAUN, M. D.,  
PASSAIC, N. J.

SEPTEMBER 8, 1893, was called to attend Mrs. M., æt. thirty-eight years, a Hungarian by birth, mother of four living children, the oldest about thirteen years. I delivered her of a full-term infant three years ago, and attended her in two consecutive miscarriages prior to the present one. She has had subinvolution of the uterus and prolapsus of the third degree for some time. Did not reach the patient's house until about two hours after being summoned. On arrival found a six months' fetus hanging from the vagina with all but the head born. On further examination discovered that the uterus was in the third degree of prolapsus, with the head of the fetus in the uterus, and the cervix tightly contracted about its neck. Without further delay I attempted to stretch the cervix by manual means sufficiently to admit of the passage of the head and after about twenty minutes succeeded in delivering the head, which was immediately followed by complete inversion of the uterus entirely outside of the patient's body. The placenta came away simultaneously with the head. I watched the patient as carefully as the occasion would permit; her pulse became very rapid, and she seemed to be suffering excruciating pain, although I observed no symptoms of shock. There was slight oozing of blood from the placental site, which was centrally located in the fundus. Immediately I placed the two first fingers of my right hand on the fundus and pressed upward, the vagina first returning into the body, then the uterus into the vagina as the parts of a telescope one into the other, and with the left hand on the abdomen continued upward pressure with the

right hand and restored the inverted uterus with very little trouble, consuming, I should judge, not more than two minutes, although I was so thoroughly surprised at the occurrence that to state the exact time would be impossible.

She experienced unusually severe after pains which lasted for four days, and made a good recovery, and to-day is in her usual health with the exception of the prolapsus, which does not seem to disturb her much.

Why this patient should not have suffered shock and the attending perilous symptoms that accompany this gravest of puerperal complications I cannot explain, except that it may be due in part to the fact that she had chronic prolapsus of the third degree for so long that her system became accustomed to the abnormal condition, and that the inversion thus added was not consequently so severely felt as if the prolapsus had not existed.

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## CONTAGION IN OUR PUBLIC SCHOOLS AND ITS PROPHYLAXIS.

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BY

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AMERICA'S pride is her common schools. Decade vies with decade, State with State, in furnishing better means of education. Edifices are erected which adorn the city and afford comfort and pleasure to the pupil. The committee on public property inspects the same, making sure of their safe structure and that egress according to size is sufficient in case of fire.

The Board of Health condemns schoolhouses improperly ventilated or otherwise in an unsanitary condition. For so

long a time have separate forms been provided that we no longer call it a modern improvement, although *that*, perhaps, was the first great step toward a healthier condition for the children. No longer could they so easily come in contact, or inhale each other's breaths.

Every city and town has its laws in regard to the so-called contagious diseases—variola, scarlatina, diphtheria, etc.—but as if ignorant of the yet more dreaded contagious diseases, tuberculosis and syphilis—more dreaded because in some cases entailing a life of suffering, if not extending to more than one generation—no protection or attempt at protection has been made.

On the other hand, with an eye single to the idea of education, separating it entirely from the necessity of a healthy body, a system of supplies—books, slates, pencils, clay, and the various kindergarten outfit—has been adopted by many cities and towns, while a dozen or more States have legislated to the same effect.

Very few of our public schools could boast that not a child attended capable of conveying disease to another, while many receive pupils loathsome to sight and smell. Should the parents of carefully reared children but visit the schools and see the filthy and unwholesome condition of many who use the supplies in common with the cleanly they would shrink with horror from that to which their children became accustomed.

An educator of many years experience gave me as his opinion that fully fifty per cent. of the children in cities attending school were too filthy to be allowed admission, and yet your children inhale the air of the same room made foul by such pupils. Cases of typhoid fever in children have been traced to this source of poisonous infection. The children who at home have each his individual toilet outfit an hour later in school are handling what filthy, diseased hands have often handled. The child who *must* have a clean glass to drink from at home eagerly uses the com-

mon cup, which often is metal, and when cleansed who can tell!

Greater attention has been given to the *prevention* of smallpox than to any other disease, and yet it holds a comparatively low rank among diseases in its deadly influence.

*Vaccination* is *compulsory*, but there all compulsion ends. To be sure, we have laws forbidding the school to children living in a house where there is illness from contagious diseases, but the experience of New England during the last six months has proven how powerless are such laws in controlling the epidemic of scarlatina. Many cases have been of so light a character as to be unrecognized, and no physician was called until some member of the family developed a more serious form of the malady; the children of such families in the meantime attended school, using the books, slates, pencils, clay, and other materials which later on will be given to other children.

Knowing the ease with which the scarlatina germ is carried from place to place and its great vitality, lasting for months, if not years, is it reasonable to expect that this disease will not again and again develop from these very germs? True it is that schools have been closed, all books, etc., burned, and the houses thoroughly disinfected when the enemy has become recognized as *sufficiently* epidemic in a given school.

The other exanthemata are likewise spread in our public schools, but being considered so little harmful to child life and health, common rule of protection is sufficient.

Diphtheria is another disease recognized as fatally harmful and therefore to be guarded against, and yet not until a case is reported to the authorities is any step considered necessary to protect the children. The text-books in our public schools furnished the pupils are in use from four to six years. These may be used one year at a time by the older, but much less time by the younger pupils, while in certain grades the readers are taken up daily or oftener

and passed indiscriminately. Hence where greatest protection is needed least is afforded. It is in young life that the lymphatic system is most active, that the tissues are softest and most susceptible to infection. How do children use books? They bury their faces in them: the child with festering eyes to-day, your child to-morrow; the child with syphilitic discharges from nose to-day, your child to-morrow. They pillow their heads in them: the child with corruption pouring from its ears to-day, your child to-morrow; the child with hair matted with filth to-day, your child to-morrow. They cough into them the catarrhal secretion which precedes diphtheria, it may be; they sneeze into them, they breathe into them.

Can a child with any abrasion upon its hands come in contact with syphilitic, cancerous, or tuberculous discharges and be exempt any more than a surgeon? And yet many a child with eruptions breeding on its hands uses the same clay to-day that yours will use next week. Cold water poured through the clay is the cleansing process. When dried and ready for use again who can tell what is in it?

The disease above all to be most dreaded and guarded against, the disease which may be, and often is, hereditary, is probably the least recognized by teacher or pupil. Although hereditary syphilis often ends in early life before the child attends school, yet it is a fact that for years it may again and again make its appearance. How can this disease be guarded against? Every child must furnish a certificate of vaccination; why not in case of eruptions a certificate declaring contagion or non-contagion? Cannot the public mind be made to understand the importance of preserving and promoting health? A few careful, thoughtful parents purchase new books, etc., and substitute them for those publicly supplied; they also provide their children with drinking cups. Were the danger lurking in these sources appreciated more would do so.

Massachusetts in 1882 took the lead among States in

providing school supplies. She has ever proved herself a leader in good works: one step *farther* in this direction will crown the deed as good. Let her supply each pupil, or at most each family, with books, etc., unused by others. But what shall be done to prevent contagion from other sources? Every home provided for destitute children that deserves the name has those suffering from specific disease isolated, or else the other children guarded from contact.

Why should children in our public schools have less careful attention? Is it necessary that disease should be disseminated with education? Is it considered democratic to allow every child the freedom of filth and contagion, whether to keep it or to impart it, as a part of his inalienable rights? However much it might at first savor of class distinction to have baths and clean clothing provided those who need them, would it not be an elevating influence? Would not the children learn a self-respect in their clean school apparel that would lead them to wish and do their part for better home surroundings? If cleanliness is next to Godliness where and how can the truth be better taught? Some will cry out against inspectors, baths, and clean apparel. They will have much sympathy for the injured feelings of the unfortunate class. Have such visited the homes from which these children come? I will not describe them. Every city has its slums.

We are here witnessing the great progress the world is making in science, art, industry, medicine, and surgery. Is it not an appropriate time to arouse the public mind to a still more important matter? So thoroughly has it been demonstrated that an educated mind can excel the uncultivated that, unconsciously, as it were, the foundation of all education, cultivation, and refinement has been made to take a secondary place. It has almost been lost sight of that a healthy body is indispensable to a *sound* mind. Of all progressive movements what will compare with the

preservation of our children's health? What of so great importance as shutting the gates that shall sap the health of not only the rising generation but of generations yet unborn?

Teach the children hygiene in a broader sense—call diseases by their names, teach your children to bathe and shun those that are accursed, and no longer consider your child tenderly reared because kept in ignorance of unpleasant, painful, disgusting *facts*.

It has been my purpose to speak but a word for child life, to give but a glimpse at the dark cloud hovering about school days.

Let us as physicians sound the note of alarm till the school world is awakened to the real though subtle danger.

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## ● EDITOR'S TABLE. ●

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IN the report of a bureau of obstetrics of one of our homeopathic societies there is a paper on "Care of the Navel and Cord" which contains about as much nonsense as we remember to have seen condensed in such small compass. The first recommendation is, "Advise the expectant mother not to turn somersets or invert the body, so avoiding risk of looping the cord about the neck or body of the child, or of tying knots in the cord, by which circulation of the fetus might be stopped." The expectant mother is also advised not to reach high, nor to jump, nor to bounce. These may be the ordinary habits of pregnant women in Pennsylvania, but women in that condition in this neighborhood are not in the habit of turning somersets. As for the motion of the arms in reaching high as having any influence upon the knotting of the placental cord we very much doubt. Whatever excites the fetus may cause it to turn and so become entangled in the cord, especially if the cord is abnormally long; but emotions on the part of a mother rather than motions will cause such movement on the part of the fetus, and the length of

the cord cannot be determined by the fact that the mother lifts jars of pickles down from her top shelf, or does any other form of manual work.

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**A**NOTHER recommendation is to tie the cord with stout thread, either carefully waxing it or else wet the thread in the mouth. While thread or any other substance may be used to tie the cord in case of emergency, if one is to be prepared in the best possible way there is nothing that will replace narrow tape, and this had better be used unwaxed and just as it comes from the shop. As for hemorrhage from the cord, this can never take place except from carelessness in tying it, and the knot should always be looked at just before leaving the case—say a half hour or more after the birth of the child. In fact, except in case of imperative necessity the accoucheur should not leave the house until a full hour after the birth of the child. More harm comes from leaving a case too soon after delivery than from any other one thing. The writer makes the astonishing admission that he lost one child by including one of its fingers in the ligature when cutting the cord, and the child bled to death before it was noticed. We are therefore not surprised that he should make the statement that delay in tying the cord is falacious; that it ought to be cut at once before pulsation has ceased, and the child may lose more blood than it may gain by pumping its own blood into the placenta. Observation of but a few cases would teach any man that the blood is never pumped back. In fact, it is not pumped at all, but is drawn by the expanding of the lungs by suction out of the cord into the circulatory system of the child. The careful experiments made by Boudin show that the child gains eight ounces by delaying the tying of the cord until it is pulseless, and that in a large number of cases held under observation the subsequent history of the child in which the tying of the cord was thus delayed was very much better than those in which the cord was tied immediately on birth.

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**T**HE author of this remarkable article also negatives the stripping of Wharton's jelly from the cord, because he says it predisposes to hernia. Having done this in several hundred cases



without a single hernia, and with the advantage that the cord mummifies and drops off without scarcely any odor or trouble, is a sufficient negation to such a wild statement, and this is the experience of many obstetricians of lengthened experience. Though there are many new-fangled ideas as to dressing the cord, and doubtless much may be said in the favor of dry dressing, still there is nothing that is better, probably nothing as good, as well smearing it with lard and rolling it up in a piece of soft old linen. If then it is absolutely left alone it will drop off on the fourth or fifth day, and the navel will heal without further trouble, and with none of the oozing of matter of blood with which the author to whom we have referred seems to have had so much experience. Thus umbilical hernia never occurs excepting in cases where the child is allowed to do a great deal of prolonged crying. In these cases of protrusion of the navel it is far better to use a flat piece of cork stitched into the binder or bandage that surrounds the abdomen, and so placed as to come directly opposite the navel, than to use pieces of adhesive plaster, because in an unhealed navel there is apt to be some sort of discharge which, under the adhesive plaster, may become foul and produce an ulcer, while simply kept in place by the cork in the bandage the whole abdomen is kept clean and exposed to the air at the time of daily bath.

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**D**R. MILLIE J. CHAPMAN read a paper on "Prenatal Medication" at the Medical Congress in Chicago last summer. The paper was printed in the September number of the JOURNAL. In discussing that paper Dr. Geo. B. Peck said among other things :

"In a New England city in May, 1848, a young wife lay upon a sick bed covered with the characteristic eruption of measles in its most intense form from head to foot, and expecting hourly the advent of her firstborn. The husband was informed he could not expect the preservation of either. Promptly on time a girl appeared, as roseate hued as the parent. The daughter fell a victim to allopathic medications three months prior to the completion of her twenty-third year. The mother is still living. Now if it was possible for morbid germs or their products to enter that uterus and produce upon its inmate the same phenomena

exhibited upon its possessor with equal rapidity, at the same time it can be no less possible for our finely comminuted preparations to penetrate equally deep and perform their appropriate functions. But again, we know that growth and development depend upon that intangible something for convenience denominated nerve force ; that variations in its quality or intensity produce corresponding variation of result ; that even maternal mental emotion leaves its impress on the offspring. We also know that we have power to produce variations in the nerve force at will, that we can produce mental impressions at will. Failure, then, to apply this knowledge can only be ascribed to indifference to the newborn or to professional incapacity. Regarding the particular attention recommended, it need only be said that too many observations have been made and recorded of physiological phenomena and drug aggravations produced by homeopathic preparations above the twelfth decimal to permit any doubt of its efficiency to be considered reasonable. It may be added that the physician who prescribes even occasionally any preparations above the twelfth decimal attenuation unwittingly adds his indorsement of that statement, and I am inclined to count in with them all those who prescribe above the sixth decimal. I cordially and fully indorse Dr. Chapman's paper, including her reference to the frequent equal importance of prenatal medication. '*Whatsoever* a man [or woman] sows that shall he [she] also reap.'"

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CONTINUING the discussion Professor Phœbe J. B. Wait said : "Before beginning my speech I would like to have had a copy of Dr. Chapman's paper and committed it to memory. It is too valuable to lose any part of it. The father of medicine, Esculapius, lived, we are told, I think, somewhere about nine hundred years before Christ. He had five children, three sons and two daughters, and all these children, admiring the skill of their father in medicine, took to medicine, the whole five, the sons and the daughters. From the three sons have descended all the doctors of the world—that is, men doctors. There were no women doctors then. And while these doctors in medicine were a long time in getting around, you see the woman has got there

just the same. So here we are descended from these two beautiful daughters of Esculapius. The one believed in preventive medicine and the other believed in curative medicine. I did not read that these sisters ever came into collision in their practice, but their fame has come down to us. Hygeia, the beautiful daughter of Esculapius, advocated the use of a medicine which I would like to advocate for prenatal medication. It is the blessed sunshine, the fresh home, the clean heart, and the loving kindness and tender mercy which should be shown for wife and expected mother. These are things which tell upon the children. If we believe in the transmission to the child of the mother's qualities, shall we not also believe in the healthy organization of the mother, and the healthy organization of the father as well, because the father has something to do with these things. Very little, you may say. However, we will give him credit for what he has to do in the matter. Do we believe in tobacco blindness, in tobacco neurasthenia? Shall we not believe that these diseases are transmitted to the child, and shall we say that any wife has her husband's full share of kindness who is brought up in the air of the vile fumes of tobacco? It is poisoning not only the husbands, but the wives and children of this land. Do we believe in tea and coffee neurasthenia? Then shall we not believe that the mothers who are sipping tea and coffee, who do not take their food, and who cannot get through the day without a cup of strong coffee in the morning? Shall we expect the children of these mothers to come out strong and vigorous and healthy? Shall we not expect them to be a bundle of nerves? I have looked at mothers, and have seen them so proud over their children, beautifully dressed, and they say, 'My little girl is such a nervous little thing that I hardly know what to do with her.' Dr. Chapman's paper is very much to the point. The medication ought to have begun in the mother of the mother of this child one hundred years ago, or the teachings of Hygeia. This is the doctor I am speaking for now.

"The other daughter of Esculapius—I am ashamed to say I do not remember her name—is immortalized in a tree, the leaves and bark and flowers and fruit of which go for the healing of the nations. I suppose the use of this tree must have been to prevent,

and it is used by the homeopathic school, because we cure all the diseases that are curable. And so it may be necessary, indeed it is quite necessary, to prescribe remedies for the mothers of unborn children. Professor Lilienthal says that cocaine and sulphur will save more children than all other remedies put together. We must not forget these remedies. Silicea, gels., etc., we will not forget, neither will we forget the remedies for those diseases which are inherited, but we will prescribe for every mother the things which we have tried to emphasize to-day, and we would prescribe if we knew enough the homeopathic drug which would remove the sordid condition in a mother, and help her. I believe children are born to live, not to die, and the fact that one-half the children of the world succumb before they are five years of age is a terrible commentary on modern civilization."

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**D**R. BUSHROD W. JAMES said: "I am much in favor of this latter daughter of Esculapius. I am very thoroughly in love with the first one that Dr. Wait has spoken of, simply because she was in favor of hygienic measures. I believe if we are going to succeed in making a good, healthy future nation, and future people and generations, it is on this very basis of this paper that you must begin your hygienic measures, not only in the surroundings by which we are encompassed. Sanitary science is doing a very good work, but it deals with the external world. It gives us good houses to live in, good air to breathe, and it gives us good surroundings in every way. That is all very good, but the foundation must be laid by placing good hygienic measures in the tissues of the human system, and you are not going to do that unless you give the proper medicine that will enable you to flush these tissues in presence of disease—make those persons healthy through hygienic measures. Give the system of a mother good blood, make the cells act in harmony, make the nervous system act properly upon these cells and upon these tissues, and how are you going to do that? The mother goes living along, she eats improper food, and is careless in her surroundings. She does not get enough light, and she probably reads herself to death, or stays up at night and goes to theaters and one place or another and ruins her health, probably by not giving the nervous system

a sufficient amount of rest. I look forward to the time when diseases may be annihilated, when the human race may reach that point of millennial health that we can do away with disease. We can do it by annihilating one after the other, and then our mission, of course, as physicians will be ended."

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I AM not foolish enough," said Dr. McCracken of Chicago, "to think I can discuss a paper that I have not read. Henry Ward Beecher once said, when asked for his rules for longevity, "Choose your father and mother," and I think that is what one would have to do to be very long lived. I remember a case where the mother shut herself up in her own house, and refused to go upon the street. Now that is God's plan of creation, and the man or woman who sneers at a woman on the street or anywhere who is fulfilling the law of God is not fit to be upon this earth. She cannot possibly bring forth an intellectually or physically strong man or woman and be shut up in a house during the nine months before confinement. Then I would make a strong cry against the dress of woman at that time. Many women think if they are tightly laced around the waist, and keep their waist measure as usual, that is all that is necessary. I think more can be done by dressing than any one thing, and then plenty of fresh air and bathing and good common-sense diet, and then I do not think there would be so much need for medication."

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DR. G. W. BOWEN: "During the first ten years of a doctor's life he has got to learn what he doesn't know, and he has also to establish his reputation as a physician. In the next ten years he works for pay. I have passed those years, and in lending a hand in creation, and in making new beings perfect, I almost equal a superior power. I know this can be done. I have spent a great deal of time in learning how we can avoid a father's indiscretion and a mother's sensitiveness. If a father has been imprudent and is liable to contaminate his child with syphilitic disorder it can be guarded against by mercurial treatment. If the mother has any peculiarity you can guard against it. I believe that as much as I believe in the materia medica. I have many times treated mothers voluntarily in order to demonstrate

what can be done. In several instances I have stopped a tendency to pulmonary troubles. If the weakness is below the belt *sepia* will surely remedy it. If there are cases which have been dyspeptic *nux vomica* and *belladonna* will prevent it. Consumption you can guard against with *bryonia* and *calcaria*. In weak heart you can guard against that surely with *bell.* and *arsenic*, and, perhaps, *calcaria*. I feel that in this treatment I am almost doing what may be considered similar to the creative power."

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**D**R. HAWKES of England then said : "I think this is one of the most important papers that we have had during the congress, and I am very glad to have heard such a thoroughly homeopathic paper. Of course I do not think that hygiene can be neglected for one moment. What I will say will be chiefly on antenatal medication. I would like to refer to some five families in about as many minutes. One disease has not been referred to this morning, laryngitis stridulus. In one family three of the children had died of it, and I was called in to see the fourth child. *Cuprum*, etc., were tried, but the child died. During the fifth pregnancy I had early opportunity of giving *calcaria* and sulphur, and in the sixth pregnancy the same course was followed, and to-day that woman has two healthy children of which she is thoroughly proud. Since that time I have saved others. In another case of trouble of the bladder, a record of which you will find in this month's *Review*, the child, a boy of two or three, had tubercular disease of the bladder, tubercular laceration. That was diagnosed by Reginald Harrison, who assisted me, and the child was cured of it by *calcaria* alone. The mother was given it, and the next child was perfectly healthy. Another child was born rachitic. The mother was treated in the same way, and the next child was born perfectly healthy. The third child, the mother not having received treatment, was born rachitic. During the fourth pregnancy I had full sway, and treated the mother in the usual way, and the fourth child was absolutely healthy.

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**D**R. HENRY of Alabama : "I am very glad to be here to-day to see this question discussed in the light of homeopathy. Take a series of abortions in a family. We commenced with our

remedies as high as the thirtieth, and we followed Hahnemann's treatment. I will say I have seen more fatality with men who offered thousands of dollars for the cure of their children, and where every single rule of hygiene was carried out. The drainage was perfect, the house upon the mountain top, and I have seen six children in one family lay down and die, one after another, with every hygienic principle carried out for months and years. I remember one case where a man said to the doctor: 'Here is a check for a million dollars if you will cure my last child.' Every sanitary measure was carried out, but the child died. Cocaine is the remedy that it seems to me the homeopathic physicians have forgotten. Muller of Leipsic published in the *British Medical Journal* of October, 1857, forty-nine pages upon coca, and he expresses the opinion that in the nervous diseases of children it is one of the most potent remedies. He speaks of the benefit of dropping it in the eye and producing a partial deadness. The allopathic physicians have taken that up and published it as something new."

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DR. J. A. WHITMAN of South Carolina: "Everyone has a hobby, but you have not hit my hobby, and that is diet. What is medicine if we do not have food? If the mother does not have the proper food to produce the nutriment for the child, what is the child? I think we should look to the table for a great deal of benefit, as this is lost sight of more than anything I know of."

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DR. DUFFIELD said: "There is one point that I would like to speak of that has not been mentioned, and that is prenatal treatment for easy childbirth. There are some children who are born with very little vitality when treated to render their bones soft. I wish to add my word of warning in carrying this treatment out. I had two years ago a little one come into this world and it has been sick ever since. The starving of the osseous tissue has had such an impression upon its body that it will never amount to anything. The treatment prior to labor had the desired effect. In two cases prior to this the mother was a great sufferer, but in this third case the mother abstained from

all those articles of diet which would permit of osseous development, and the result to the little one was starvation."

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PROFESSOR TOOKER read a very interesting paper on rachitis which we also published in our September issue, and this paper was discussed by several persons, but not as thoroughly as its merits deserved.

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DR. BUSHROD W. JAMES said : " This is one of the diseases that will come under my idea of annihilation. I apprehend that the disease does not always originate from an insufficient amount of nourishment. There seems to be some abnormal condition of the body which requires a remedy. We must endeavor to cure this disease as we find it. The symptoms are : a sweating of the head, the very great irregularity in teething, showing that the osseous structure is not getting its proper amount of material for building up the teeth, and then there is likewise a determination of too much or too little material to one structure or another. In the application of our remedies we endeavor to harmonize all the tissues, and make them go on as nature intended throughout the economy. In regard to the best remedy I fully coincide that it is phosphorous. I have been in the habit of giving calcaria phosphori, which answers every purpose, and is perhaps better in many cases. Frequently the glands of the intestinal tract are involved, those of the neck and other parts of the body being greatly disturbed, and calcaria carb. is a magnificent remedy in that condition. There is an excellent remedy where anæmia exists, which is baryta carb. Then there is another remedy I was thinking of, and that is sulphur. I think sulphur is an admirable remedy to add to the calcaria. I believe in many cases that, with all your efforts, you may not be able to change the condition of the system, and yet in many cases you can do a great amount of good by adopting a homeopathic remedy, as has been suggested."

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DR. DUFFIELD said : " I had a case in my student days which was a very good illustration of this rachitic condition. It was a negro boy of four years. He was unable to stand ; his legs were



bowed and crossed, and he had a very large head on a very little neck. There was a hole through the spinal column and the soft matter could be touched with the finger. His pulse was 204, and his temperature was 105°, and the pulsation of the heart was so pronounced that you could see it through the chest wall.

Physicians of the opposite school said he would not live twenty-four hours. I had heard the lectures on *calcaria carb.* and used it then. The next day I found my little patient was better, and as I went day by day he improved, until finally in the course of six months he was able to stand up and get around by holding on to the chairs. I gave the *calcaria carb.* in the 3x trituration, at first once an hour, and then once in three hours, and then every other day."

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PROFESSOR C. D. CRANK: "I think one mistake lies in the fact that rachitis is not recognized early enough. I will give you three symptoms in recognizing this disease. First, a peculiar watery discharge from the nose; second, a peculiar wakefulness and restlessness at night—touch the crib and the child will start; third, the sweating of the head. It may be rachitis, it may be *tabes mesenterica*. If the child lives long enough it may be epilepsy. If you wait until the trouble is developed you will have difficulty in treating it. *Calcaria phos.* is a good remedy, and there is another remedy I resort to successfully. It is not medicine, but it is a food that feeds the nerve centers, and I refer to oils. Rub it with the best olive oil, and feed it on cod-liver oil to build up its little organism. These conditions are the result of worn-out nerves."

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IN closing the debate Professor Tooker said: "I am rather disappointed that no one has taken exception to some statements in my paper. I can only repeat what I said in the paper, that I think it a great mistake for the average American woman to nurse her babe beyond twelve months. Her milk then becomes thin and watery, and the babe should not be nursed through the second summer. We have artificial foods that will be far better substitutes.

"Now let me enter protest against another practice I find

common among physicians, and that is correcting the acidity of the milk by keeping the milk in an alkaline condition by the addition of limewater. It is a very irrational practice. If you want to correct the acidity give soda, which is far better than limewater."

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THE Awkward Gait of Children " was the title of a well considered paper by Professor Sidney F. Wilcox of New York. This paper was also published in our September number.

Dr. Sarah J. Millsop in discussing it said : " It is with hesitancy that I comply with Dr. Pardee's request to discuss this paper, for the reason that I belong to that large and formerly very useful army the general practitioner, now being relegated to the top shelf as back numbers. We have been told here that women have not been asked to take a more active part in these deliberations for the reason that they were not specialists. But as all women are specialists in diseases of children I may venture to say a few words on this most important subject—a subject to which not enough attention is paid, as the awkward gait of children means when not corrected the awkward gait of men and women. In the South where I live I have found it positively painful to watch the crowds of country people who flock to our city on what is called "Show Day." So many have not only an awkward shuffling gait, but they are round-shouldered, slouching, knock-kneed, and club-footed. This I think in a great measure is the fault of mothers who, not realizing the importance of forming correct early habits, being burdened with domestic cares, leave their children to "grow" like *Topsy*, or to come up haphazard like the young of the lower animals, but without their natural grace of motion. In my opinion a judicious course of calisthenics in the school or at the home would do much not only to prevent but to counteract the bad conditions the doctor refers to. Where the muscles are at fault from a weakened condition no better measure can be recommended than the use of massage, with inunctions of some nutrient oil. Where a constitutional dyscrasia underlies these bad conditions our materia medica will give us most effectual aid. We have doubtless all found a most potent ally in our calcarias, especially in calcaria phos., in overcoming deformities

in children. One dietic measure I should recommend above all others is the use, in some form, of the entire wheat. Chemists tell us that the kernel of wheat contains not only most of the elements needed in the system, but just in the proportion in which they are needed, even to the constituents of teeth, nails, and hair. That our children are fed on the least nutritious portion of this cereal which forms our "staff of life," while the most nutritious portion is given our lower animals, may account for the greater physical superiority of the latter. The whole wheat is not only a builder up of the young, but there is nothing to equal it as a repairer of waste tissue in the adult. Its constant use will keep brain and body young and active long past the allotted three score years and ten."

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**C**ONTAGION in our Public Schools" is the title of a paper by Dr. Lucy C. Hill, printed in this issue. The paper was read at the Medical Congress last summer. In discussing it Dr. Geo. B. Peck said : "It has been my privilege to serve as member of a school board nearly fifteen years and to graduate from the public schools, but I have never seen a counterpart of the scene portrayed by the essayist. So far as my native city is concerned, and of that only can I speak definitely, the picture is entirely overdrawn. Children loathsome to sight and smell are not found in the public schools of Providence ; should they apply for admission they would promptly be directed to return home and wash. Where that educator lives who finds fifty per cent. of the pupils too filthy to be allowed admission I cannot conceive. It probably is outside the United States, and certainly is beyond the limits of New England. The dangers of modeling in clay are obviated in my schools by excusing children with sore or cracked hands from the exercise ; those of syphilis by sending those with noticeable eruptions to myself or to the Superintendent of Health for examination ; those of tuberculosis are practically nil. Children do not use books as described. If typhoid fever has been proven to result from the inhalation of air befouled by the breaths of dirty children, alas for the stability of bacteriology and the germ theory. The essayist declares that 'where the greatest protection is needed the least is afforded.' That statement I

deny. I never have seen any statistics that afford the slightest foundation for the popular idea that children are more susceptible to certain disorders than adults, though I have searched long and widely. I should like to find a single iota of evidence that the seclusion of a child from scarlatina germs until ten or even fifteen years of age will diminish in the least his liability to contract the disorder upon the first exposure. On the contrary, I believe that the children of the common people, those who cannot attend school beyond the age of fourteen years at the farthest, are cruelly robbed of a very considerable portion of their educational opportunities by unnecessarily rigid sanitary regulations. In the average family of four, unless it should chance that all are sick simultaneously or during vacation, each one is unjustly and to a great degree needlessly deprived of at least one-seventh of its school advantages, crippling to that extent its ability to fight life's battle, darkening to that extent its life's prospects. That is a point never considered by rabid sanitarians."

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THE Headaches of Children " was discussed at the Chicago Congress. See September, 1893, JOURNAL OF OBSTETRICS.

Professor Waite said: "The last paper read was especially interesting, because I believe so many children suffer from headaches when they ought to be made comfortable and cured, and the one case above all others which gives suffering to children I believe to be due to eye strain. As soon as they are put in schools they commence to droop. If the child is myopic there is a request that he be put in the front of the room, but no thought is given to the hyperopic child. I believe the uses of the ophthalmoscope are going to prolong the lives of children in bringing out this infirmity. Many children suffer from headaches, but we have our pulsatilla and kindred drugs to help them. If your child suffers with headache don't forget to take it to the oculist. This would be a beautiful specialty for a woman."

Dr. Duffield said: "There are many cases of near-sightedness which can be cured simply by having the patient accustom himself to distant objects. Take them out in the country, and in this way we get the muscles stretched, which is as good as nerve

stretching in other cases. I have cured cases of near-sightedness by having the patient go to live in the country, and so accommodate her eye to long distances."

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ALBUMINURIA in Children" was the title of a thoughtful paper by Dr. Henry Aldrich. In discussing it Professor Van Baum said: "Albuminuria in children is frequently overlooked, especially in private practice, in cases presenting none of the well-known characteristic symptoms usually accompanying the disease. The oversight depends upon a lack of frequent and systematic urinary examinations. It is now axiomatic that the younger the child the less dominant the "old-time" symptoms. The indications often point to involvement of organs remote from the kidney center; for instance, a simple high fever may be present, or vomiting, purging, and collapse, or drowsiness and mild convulsive seizure, or simply anæmia. The common cause of albuminuria in children is Bright's disease as a sequela of the acute infectious diseases so frequent in childhood. Again, Bright's disease may exist without any apparent cause and practically without indicating symptoms in children even as young as six months or less. In these cases when a urinary analysis is desired the urine can be collected by keeping the child on pieces of well-boiled linen on a rubber pad for some hours. By this method sufficient urine can be wrung out to give the desired chemical and microscopic tests. A sterilized silk sponge can be used in the same way. If retention is present a small catheter will secure the fluid. Pus, blood, or chyle are rare causes of albumin in the urine of children. Morbid growths resulting in pressure will also give rise to presence of albuminuria. The most interesting phase of the question of albuminuria in children is the so-called functional albuminuria. By this is meant a renal albuminuria with absence of casts and all characteristic signs of Bright's disease or any other disease, the victim being to all intent and purpose in perfect health. The claim has been made that this condition is more frequent in boys than girls. In cases of adolescence this seems to be established. It frequently accompanies the habit of masturbation. The amount of albumin present varies greatly; sometimes it is quite large. As a rule, it is limited; some in the

morning, more at noon, and none at night ; or, again, there may be none in the morning and quite marked at night ; or, when the patient has been resting in bed, it may disappear altogether, remaining absent for some days after resuming the usual occupation of the day, and then from some apparently insufficient mental emotion or excitement a large quantity may reappear. The ingestion of food, or certain articles of food, like eggs, seems to cause it to return. Time and again the chemical urinary analyses show an entire absence of albumin in the morning urine with a gradually increasing amount as the day advances, being highest in urine voided on retiring. For this condition no attributable cause can be determined, excepting the daily muscular activity of a child in contradistinction to the night's repose, which gives a morning urine free from albumin. If exhaustive microscopical examination fail to give evidence of Bright's disease, such as tube casts, renal epithelium, etc., then the cause of the albuminuria becomes speculative and unsatisfactory. To many authorities the diagnosis of functional albuminuria, or albuminuria of adolescence, is sufficient, while others fail to accept this conforming opinion and view with apprehension intermittent paroxysmal albuminuria or the daily recurrence of a slight albuminuria as indicative of the existence of some unrecognized kidney lesion, or, at least, as the advance signal of the oncome of some form of Bright's disease. I hold with the latter and view skeptically the existence of a physiological albuminuria. The diagnosis of these masked conditions is extremely interesting and vexatious. I recently came in contact with a case in a girl, aged thirteen, who had an attack of diphtheria, with secondary glandular involvement. She convalesced nicely. On the fourteenth day the temperature rose suddenly to  $103^{\circ}$  F., with albumin in a scanty urine, amounting to nearly one-half the amount of urine examined in test tube. The temperature fell rapidly, the albumin diminishing in pace with the fall of temperature, the latter remaining stationary at  $99^{\circ}$ , and the urine containing a trace of albumin for four weeks, no tube casts ever being present. The following six weeks the urine was tested as follows : A morning, noon, and night sample, separately, every other day and a twenty-four hour sample every second day with negative results. The menstrual function was

then established, and albumin appeared regularly for five days without casts. Then a period of six weeks passed without albumin, followed by a reappearance of albumin after a short period of nervous excitement, and so on. The question in this case arises, When was the albuminuria established? Was it the result of the diphtheria, or did it exist beforehand? In either event, there being no other symptoms but a high fever and a scanty urine at the time of the discovery of the albumin, the prognosis must be of the tentative or experimental type. The lesson to be drawn is the necessity of careful, exhaustive, and persistently repeated examinations of the urine for casts, in order to establish a diagnosis and prognosis in the by no means infrequent cases of albuminuria in children without symptoms."

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## NOTES ON CURRENT LITERATURE.

### PRACTICAL MIDWIFERY.

A WORK which has reached eight editions in England and six in America hardly needs further commendation. Everyone who is at all familiar with the literature on midwifery knows Playfair's work,<sup>1</sup> which may now almost be classed as a classic. It is sufficient to say that the sixth American edition which has recently appeared with notes and additions by Dr. Robert P. Harris of Philadelphia presents the entire topic of pregnancy and parturition in a manner which leaves very little to be desired. The work is moderate in compass, and yet coming as it has from the hands of a practical man combines all that really need be said upon the subject. If those who practiced obstetrics were all of them completely familiar with the knowledge contained in this book we should not have so many women disabled by child-bearing, nor so many children lost during the first few weeks of life. While on this subject, as on every other, there are reason-

<sup>1</sup> A TREATISE OF THE SCIENCE AND PRACTICE OF MIDWIFERY. By W. S. PLAYFAIR, M. D., LL. D., F. R. C. P. Sixth American from the eighth English edition, with notes and additions by ROBERT P. HARRIS, A. M., M. D. With 5 plates and 217 illustrations. Philadelphia: Lea Bros. & Co., 1893.

able differences of opinion, still if we were compelled to recommend one work alone we should accept Playfair as a standard. It is now almost twenty years since the first edition of this work appeared, and a comparison between it and this the eighth edition shows how much more correct and scientific our knowledge in this department of medicine has become. The present edition contains five finely executed plates and a wealth of illustration in the text, many of these so deftly delineated as to quite replace the necessity of seeing the actual subject. As, for instance, on p. 186 is a view of an extra-uterine pregnancy at term which is so beautifully drawn that anyone who has ever seen such a case cannot fail to be charmed with it. What is true of this illustration is true of very many of the others. In fact, for delicacy and accuracy of drawing the illustrations in the present edition are far superior to those of any previous one. It is a work that may well find its place in any physician's library, and the young practitioner if he proposes to practice midwifery at all can hardly do without it.

#### THEORY AND PRACTICE.

PROFESSOR WHITTAKER of the Medical College of Ohio at Cincinnati is well known as an able practitioner and teacher. It is therefore with great pleasure that we recommend a handbook on practice from his pen.<sup>1</sup> His description of disease is accurate, and one who has familiarized his mind with the symptoms as here displayed can hardly go astray in actual practice. His points in diagnosis are well considered, more particularly his differences between any particular disease and the analogous ones. In treatment we differ very greatly, as we, of course, must from any work written from the allopathic standpoint. Professor Whittaker, however, depends largely in his therapeutics upon hygienic measures and the use of heat externally and internally, in its various forms, and with many of these uses we can fully coincide. The work is

<sup>1</sup> THE THEORY AND PRACTICE OF MEDICINE, Prepared for Students and Practitioners. By JAMES T. WHITTAKER, M. D., LL. D. With a chromo-lithographic plate and three hundred engravings. Octavo, 840 pages; more than three hundred engravings and one chromo-lithographic plate. New York: Wm. Wood & Co., 1893.



especially good and full in the infectious and parasitic diseases, and while there is nothing especially novel either in idea or treatment, the statements are clear and not too elaborate for the ordinary mind. As a reference book in symptomatology it can be highly recommended. Like most old-school authors he excessively extolls vaccination, and to justify its importance describes smallpox in lurid style. Having had some opportunity to see the disease in the unvaccinated, and to compare it with other contagious and infectious diseases, we do not see how any sensible man can express such superior horror for smallpox in comparison with other exanthemata. This much we do know, that homeopathic medication will control smallpox and prevent the evils which are said to arise from it, including death. In fact, homeopathy here shows its superior excellence the same as it does in diphtheria and scarlet fever and cholera and other serious complaints. We will get rid of all these diseases when our several communities become sufficiently enlightened as to live in a state of perfect sanitation. If the hundreds of thousands of dollars which are spent every year on public vaccination were spent on making the people conversant with the best means of securing good health we should have even less smallpox than we have now, as well as less of all these filthy diseases. It is quite within our power to get rid of them all when we learn as a unit to keep clean. That is something we have not learned yet in New York, and probably we are no worse off than our neighbors.

#### A MEDICAL DICTIONARY.

I do not know just when the first edition of Dunglison's Dictionary of Medicine appeared, but probably there is no practitioner now living to whom Dunglison was not a familiar word in his salad days. Sufficient to say that it has now appeared in the twenty-first edition thoroughly revised and greatly enlarged.<sup>1</sup> It

<sup>1</sup> A DICTIONARY OF MEDICAL SCIENCE, containing a full explanation of the various subjects and terms of Anatomy, Physiology, Medical Chemistry, Pharmacy, Pharmacology, Therapeutics, Medicine, Hygiene, Dietetics, Pathology, Bacteriology, Surgery, Ophthalmology, Otology, Laryngology, Dermatology, Gynecology, Obstetrics, Pediatrics, Medical Jurisprudence, Dentistry, etc. By ROBERT DUNGLISON, M. D., LL. D. Twenty-first edition,

exhibits a great deal of skill on the part of the printer, the words standing out clearly from the page, and the page itself of a convenient size. As now issued it seems to possess all the qualities inherent in a good lexicon. Although large numbers of obsolete words have been dropped, and an effort been made to modernize the work, still we notice as we turn over the pages a large number of words which have very little practical value to the student or practitioner. Still a dictionary maker has much of that same ambition that a laparotomist has to count up his numbers, and the larger number of characters that can be crowded between the covers of a dictionary seem in the ideas of some to add to its value. There is one thing, however, that has always been true of Dunglison, that there is no mistaking the meaning of his definitions. They are tersely expressed in good English, and this would seem to be the best thing that could be said about any dictionary. There have been so many new lists of medical terms put out during the last decade that it is hard to say which is the best, as each have some particular excellence, but anyone in need of a work of this sort can hardly go wrong in buying a copy of Dunglison, for it has this advantage over many of its compeers, that it is a recognized authority wherever the English language or medicine is known.

#### MATERIA MEDICA.

IT is one of the curious things of life on earth that everything moves in cycles. This was recognized three thousand years ago by the writer of Ecclesiasties just as we recognize it now. It is true, at least in a superficial sense, of things intellectual as it is of things mundane, and Dr. Dewey, whom we are glad to welcome back again to New York and the fellowship of our local societies, gives an illustration of this in his little work on the essentials of the homeopathic materia medica which has recently appeared.<sup>4</sup> He has cast his book in the Socratic method of thoroughly revised and greatly enlarged, with the Pronunciation, Accentuation, and Derivation of the Terms, by RICHARD J. DUNGLISON, A. M., M. D. Philadelphia : Lea Bros. & Co., 1893.

<sup>4</sup> **ESSENTIALS OF HOMEOPATHIC MATERIA MEDICA**—Being a Quiz Compend upon the Principles of Homeopathic Pharmacy and Homeopathic Materia Medica. Arranged and compiled especially for the use of students of medicine. By W. A. DEWEY, M. D. Philadelphia : Boericke & Tafel, 1894.

question and answer, and will probably succeed in this way in impressing the ideas that he puts forward upon the minds of students better than if these same ideas were arranged as they ordinarily appear in works on *materia medica*. As he well says, the book contains nothing but essentials, that is to say, every student of medicine, and surely every practitioner, should know all that this little book contains and be able to apply it instantly in all cases. Still we fear that there are many practitioners who might read this book with a certain feeling of novelty. If our suspicion is correct it would be well both for their patients and themselves if they would make these essentials their own. The book is so moderate in compass that it can be most earnestly recommended to every student, and we echo Dr. Dewey's request that it shall not be used for the purpose of cram.

#### THE "CHRONIC DISEASES."

MESSRS. BOERICKE & TAFEL propose to reprint Hahnemann's "Chronic Diseases." As is well known, this work has long been out of print and unobtainable. The only English edition ever published was issued in five small volumes in 1845 and bound in black cloth. It is proposed to reissue the whole in one volume, in which case it will make a handsome book of about twelve hundred pages. The price will be eight dollars to subscribers. For historical reasons this work should be in the library of every homeopathic practitioner.

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#### MISCELLANY.

NEW, SAFE, AND SURE METHOD TO EXPEDITE DIFFICULT LABOR.—Dr. M. L. Brown, in *Boston Med. and Surg. Jour.*—From the experience I have had in the use of this method, I am satisfied that it is a safe, sure, and satisfactory help in the delivery of difficult and retarded cases of labor, with either breech or vertex presentations. Briefly, the method consists in applying a force synchronously with the natural labor pains, by and through the hands of the obstetrician, so spread as to embrace as large a portion of the fundus of the womb as may be possible, and applied downward and backward in the direction of the axis of the pelvis.

The following are directions which should be remembered and followed in making use of this method :

1. As to the position of the patient. It can best be made use of when the patient is crosswise on the bed, in nearly the same position as when the forceps are to be applied.
2. The hands of the obstetrician should be so spread as to embrace as large a portion of the fundus of the womb as possible.
3. The force should be applied when the pain commences, gently at first, gradually increasing it to the end of the pain, and should cease with the pain.
4. The force should be applied downward and backward in the direction of the axis of the pelvis.

Finally, certain precautions should be borne in mind in the use of this method :

1. It should not be used unless the presentation is a safe or deliverable one.
2. It should not be applied spasmodically by jerks, but with a gentle, gradually increasing pressure.
3. It should not be used unless the os uteri is dilated or dilatable.

Following the above directions, and bearing in mind the cautions given, this method will, I am sure, be found of great value in difficult and retarded cases of labor, and for the average general practitioner safer than the forceps.

**INVERSION OF THE UTERUS.**—Decio Carlo (Nouv. Arch. d'Obstet. et de Gyn.) reports two cases of amputation of the uterus on account of inversion. He observes that inversion occurs but once in nineteen thousand labors. It may occur at the moment of expulsion or extraction of the child, or at the close of the third stage. Inertia of the uterus is the essential cause.

The ætiological importance of intra-abdominal pressure and of traction upon the cord, except in inversion of the first degree, the author denies. These causes can produce complete inversion only when associated with inertia of the uterine muscles and the absence of all resistance at the external orifices. The author's views of the ætiology are summed up in the following propositions :

Inertia of the uterus, and, above all, that of the inferior seg-

ment, together with a sufficient dilatation of the cervical orifice, is an essential condition of inversion.

Intra-abdominal pressure is incapable of producing inversion.

Traction on the umbilical cord is not of itself alone a competent cause of inversion.

The theory of spontaneous inversion as the result of irregular contractions is not tenable.

Regular contractions may complete the inversion if it has already been begun by other causes.

The infrequency of this accident is explained by the necessity for the co-operation of a large number of causes.

For the treatment of inversion the author recommends amputation when ordinary attempts at reduction fail. Statistics show a lower mortality after ligation, amputation, and suture of the stump than under other modes of treatment.

His method is as follows : A provisional elastic ligature like that of Esmarch is applied for hæmostasis. An incision is made cautiously through the anterior wall of the uterus in the median line. The cavity is then explored with the finger, and if an intestinal loop is found it must be gently reduced after loosening the elastic band. Adhesions, if any, are separated with the finger ; this done, after again tightening the ligature, the operator immediately proceeds to pass the suture.

The uterus is then amputated below the ligature with bistoury or scissors. The sutures, which traverse the entire thickness of the stump, are tied. The band must be removed cautiously, and if there is no hemorrhage the vagina is packed with iodoform gauze.

**HYSTERIC FEVER.**—Sarbo (*Medicinisich-chirurgische Presse*) says that there are two forms of hysterical fever ; one is continuous and the other paroxysmal. Both are of a functional nature.

The following characteristics will serve for differential diagnosis : Hysterical fevers cease suddenly ; their course is irregular they withstand antipyretics ; the pulsations are exceedingly high in relation to temperature elevation.

These fevers may accompany simple hysteria and hysterio-epilepsy.

# THE HOMEOPATHIC JOURNAL OF OBSTETRICS, Gynecology and Pedology.

EDITOR, GEO. W. WINTERBURN, M. D.

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## SOME VIEWS ON VACCINATION.

BY

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NEW YORK.

AT a recent meeting of the New York Pedological Society the question of vaccination was brought up, and a discussion followed, rather favoring compulsory vaccination in the old manner as introduced by Jenner a century ago. According to my idea vaccination has not shown the value which is attributed to it by its advocates.

To begin with, we should consider three points with reference to this subject :

1. The fluctuation in epidemics generally, regarding degree of severity, and their absolute absence for a great number of years in certain localities.
2. The modern methods of quarantine and isolation of patients suffering from epidemic disease as the most effective protective measures to others.
3. The barbarously antiquated method of vaccination,

which is admitted to be not free from dangers to the subject vaccinated, nor absolutely protective against subsequent infection.

With reference to the first point we have to consider the history of epidemics generally and of smallpox in particular; next, the question whether the introduction and spreading of vaccination bear any relation to the decline of smallpox epidemics. Haeser in his "*Geschichte der Medicin*," 1882, vol. iii. p. 559, says: "The most general and pleasant experience in the history of epidemics is their constant decrease in number and severity, which is especially marked in the eighteenth century. The most fertile causes for epidemics diminish in proportion to the continual increase of the resisting powers of the people, influenced by the cultivation of the soil, the improvement of food products, and the constant advance of mental and moral education."

Liebig used to estimate the standard of a nation's civilization by its use of soap.

The decrease of dysentery Heberden explains by the improvement of social conditions, especially of ventilation. Harty refers it to the decrease of violent fevers, the complications of which are the worst accompaniments of dysentery.

But the most natural explanation of the above facts, the decrease in epidemics, is found in the rapidly progressing civilization, education, drainage, and general cleanliness. The centers of new invasions will be found in the filthy parts of the population of large cities to-day as heretofore.

Our knowledge of dysentery has not much increased during the nineteenth century, because this very disease belongs to that class which has become extremely rare as an epidemic. The cause for its absolute subsidence is just as unknown as is its markedly frequent appearance during the prevalence of acute exanthemata, and its relation to malarial diseases, typhoid states, and diphtheria.

While scarlet fever and dengue became more and more

prevalent throughout England and America about the year 1824, smallpox was materially decreased, and it was noted by the historians of that time that this reduction, or rather fluctuation, of smallpox appeared remarkable in that relation. *Apparently* reduced by the increasing vaccination in almost all countries of Europe since the year 1800, the surprise was the greater when since 1814 smallpox became excessively prevalent. In the years 1814-17, after measles, roetheln, and scarlatina, it advanced from Switzerland (entirely by contagion) in a northwesterly direction. A mild form was predominating, and therefore, notwithstanding the large number of persons affected, the death rate was small— $2\frac{1}{2}$  per cent. of the affected ones. Of all the vaccinated children but two died. (At that time there were no vaccinated adults.) But also with non-vaccinated children the course was generally without danger. Those who had been inoculated after the old fashion with smallpox virus became seriously ill. In relation to this it was surprising that in Baden, at the same time, with the same extent of vaccination, smallpox caused a mortality of ninety per cent. In the following years up to 1822 smallpox spread through France, Holland, England, Germany, Russia, and America.

After 1827 marked decrease of smallpox epidemics was noted all through the civilized parts of the globe, until again in the years 1830-60, notwithstanding the most vigorous and general vaccination, an increase of smallpox was observed, the climax of which fell in the years 1834, 1846, and 1858.

Parallel with these phenomena we find the strong prevalence of scarlatina and also of measles, which always seemed to travel from south to north, and from east to west. In London the mortality had reached an annual average of 1891 deaths during the period 1840 to 1850, and in 1851 the death rate rose up to 1956, and the following years even higher.



In France we find scarlatina running parallel with smallpox, with the peculiar observation that the more severe the one the milder the other. The statement of Von Bulmerincq that the fluctuation of smallpox depended mainly upon the condition of compulsory vaccination does not appear substantiated by the fact that in Bavaria the spread of smallpox was not as large as in England and France, because England especially had at that time enforced the law and carried it out to as large an extent as any other country; and by the additional fact that also in Prussia, known for its rigorous enforcement of vaccination, the spread of smallpox was enormous. In the five years of 1857-61 official statements show that in the entire monarchy of Prussia not less than 81,292 persons were infected, of whom 7998 died. And there is no doubt that the actual number even surpassed this when we remember that many cases were never reported.

After having been dormant again for ten years smallpox became epidemic in the years 1870-71 and spread all over the world. It was especially prevalent among French soldiers who were brought prisoners to Germany, and who infected the German inhabitants in a very marked degree. Then vaccination fell into discredit on account of the apparent insufficiency of protection, and especially through the coinoculation of dyscrasia, especially syphilis.

Since that time, the recollection of which will be in the minds of a good many physicians to-day, we have had no real epidemic of smallpox; and it was then that isolating hospitals were built all over for the sake of quarantine in addition to vaccination. If we therefore follow history we clearly see that not by any prophylactic the spread of epidemics as such can be stayed. *A modification of the disease character is possible by the immediate influence of the prophylactic, provided the latter stands in direct or homeopathic relation to the former.*

To quote Haeser again; he says in his retrospect on

p. 956: "The most pleasant and general observation in the history of epidemics is the constant, if slow, decrease of the ravages caused by them ; for even the number of lives lost by cholera is not in any way in proportion to that lost by typhus and typhoid epidemics, and especially through pestilency." This undeniable decrease and moderation of epidemics is especially accounted for by two facts :

First. By the mitigation of their direct causes, the main one of which is filth.

Secondly. Through the constant increase of civilization.

The influence of the aforementioned conditions is especially marked in malarial diseases.

All through Europe the constant decrease of this group of diseases can be traced to the more extended drainage of swampy regions, the spreading cultivation of the soil, and the improved methods of building dwelling houses. This goes so far that in many regions where malarial diseases were endemic in former times they are absolutely unknown at present. The same holds good with pestilency, which has disappeared entirely from Europe, and is at present very rare even in the Orient. Similarly typhus and variola have decreased in frequency.

The apparent increase in typhoid simply depends upon the more careful distinction between the latter and exanthematous typhus, and also upon the modern increase of reports published.

Next we find that with the increase of vaccination the decrease of smallpox is by no means parallel. At the time that vaccination was introduced, and more and more favored in various countries, smallpox rapidly decreased. Now a moment's reflection will at once convince us that this decrease could certainly not be due to the recently introduced vaccination, simply for the reason that not one-thousandth part of the community was vaccinated, notwithstanding the epidemic was on a rapid decline. And the same phenomenon had been repeatedly observed before

without any prophylactic in the same countries, at various times, and with various other epidemics. Again, after a thorough vaccination throughout the European countries, and after a long period of rest, violent epidemics swept over the land, disregarding vaccination and attacking young and old, vaccinated and unvaccinated.

Instead of reflecting in the face of such facts that vaccination did not fulfill the expectations that were promised by those who advocated it, the method of revaccination was introduced at longer or shorter periods, as appeared arbitrarily necessary. Thus after the discovery of the fact that vaccination would not protect for a lifetime (Jenner's idea) revaccination was considered sufficient if repeated once in eleven years. After revaccinated subjects became affected with smallpox, seven years was considered proper; when that proved insufficient three years; and in addition whenever a new epidemic would appear even the revaccinated ones would be again vaccinated.

The question now is: Does vaccination really protect absolutely against, or modify, smallpox? An absolute protection is not claimed by even the most enthusiastic advocates of vaccination to-day. Therefore they advise revaccination, by all means, at every new outbreak of the epidemic. Its modifying influence, however, cannot be denied even by the most enthusiastic anti-vaccinationist, especially if vaccination had been effected just prior to the outbreak of the disease. It appears to me that the nature of things would explain this modifying influence, vaccinia being an altered variola. In other words, the active principle of the variola poison, after having passed through a system different from the human, as, for instance, a calf, is suddenly changed in its quality, as proved by the early inoculation into the human organism. It has lost its identity, it has become a similar affection, it is not an *idem*, it is now a *simile*. We have seen the effect of the *idem* in former centuries when inoculation or willful

exposure to the smallpox poison for the sake of protection was practiced with the most terrible results. Vaccination, however, would not have found as many adherents throughout the medical profession if some virtue could not be attributed to it. Statistics show that the experience of those who have watched the effect of smallpox upon recently vaccinated subjects that there is a modifying influence, and if persons die of smallpox who have been vaccinated, this vaccination had certainly taken place years ago and had lost its effect; because there must be a limit to the effect of this remedy as well as to that of any other. It is therefore neither true nor logical that homeopathic physicians should oppose vaccination; for it would be an inconsistency with their own doctrine. Hahnemann argues in his introduction to the *Organon*: "Could vaccination protect us from the smallpox otherwise than homoeopathically?" Hence we must look for other reasons. Allopaths are anti-vaccinationists from sad experience in carrying out their duties as vaccinators.

The *principle* of vaccination is, in my opinion, *correct*, and based upon a sound law of nature. Its *execution*, however, I consider *antiquated, barbarous, filthy, and dangerous*; at the same time *unnecessary*, as for prophylactic effects homeopathic physicians can do better.

It is antiquated because of its being a simple modification of the old method of variolization, and only the same process in a modified form, fortunately of less hazardous consequences.

It is barbarous because it forces an individual who is at least irresponsible, feeble, and helpless to have a poison introduced into his blood which causes a disease which may prove painful, weakening, and perhaps leave lifelong blemishes, at the same time conflicting absolutely with the liberty of the individual, to which everyone has an inborn and sacred right which has to be respected by all men. But what matters it to others? Religious fanaticism has

burned thousands at the stake. Patriotism has killed millions of our best blood, our strongest manhood, on the battlefield. Why should not a few hundred useless, helpless infants be sacrificed for the protection of the race?

It is filthy because a filthy matter, a direct, unaltered product of disease, is introduced into the pure blood of a healthy human being. With it diseases of the most objectionable source can be introduced. The records of innumerable cases of poisoning by syphilis, tuberculosis, and septic material are open before us. With all precautions these unfortunate accidents can be, perhaps, lessened, but not absolutely avoided.

It is dangerous because even in its regular course it can and does produce erysipelas, spreading from a simple dermatitis of the areola of the vaccine vesicle. Defenders may say that in surgical operations any simple wound may be followed by erysipelas. True, but the very nature of the vaccine process induces this calamity much more readily than a simple wound, and as long as such a cause can be avoided why insist upon continuing it? In feeble constitutions it can and does so diminish vitality that otherwise harmless complications cause death.

The peculiar feature in the law of compulsory vaccination as practiced in the city of New York, and which has always puzzled me, is this: A child will not be admitted into a public school unless vaccinated, because of the danger to its schoolmates. Considering that none but vaccinated children are admitted, who are thus protected against contagion, according to the convictions of the vaccinators, why should a non-vaccinated child endanger these protected subjects? and why should he endanger them more than if he were vaccinated? If suffering from smallpox he certainly would not go to school, and as a medium for carrying the disease in his clothes or upon his person he is just as likely to do so vaccinated as unvaccinated. I therefore do not understand the legal mode of thinking which forces a

child to be vaccinated for the sake of protecting already vaccinated others. The danger, if there be any, would certainly be on the side of the unprotected child, not on the side of his protected schoolmates; and if he or his parents (who are his natural guardians, and who are certainly more imbued with love for their child than the school authorities and the city boards of health) have no fear of this imaginary danger, why should the child be denied school education? But public school education is the legal demand of the people; protection against smallpox a fashion with problematic value. The prohibition of unvaccinated children to enter school handicaps their obedience to the law of public education and should be abolished. Actual protection against invasion of smallpox, as well as of any other epidemic, can only be satisfactory by strict isolation of the patient and the practice of quarantine to its fullest extent. The best proof of the efficacy of quarantine has been given us by the recent cholera epidemic, which was thus restricted to some isolated points in Europe, and prevented from spreading even to the nearest neighboring towns. Why not do the same with smallpox? Why should prophylaxis be more trusted than isolation and quarantine? And if isolation and quarantine were rigidly enforced, this would show that an additional protection by a questionable and objectionable substance is superfluous. There has been no prophylactic against cholera, still simple isolation and quarantine have stamped it out.

But granted that a modifying influence can be produced in individual cases of smallpox by the introduction of a substance similar in its effects upon the human organism, why not use this substance, which is homeopathic to the disease against which it is to protect, in the form customary in homeopathy, that is, in a potentized form? Who would think of administering medicinally any of the animal products in its crude state? Some of them, like snake poisons, have proved to be inert when brought in contact

with the unabraded mucous surface, only showing poisonous effects when introduced into the blood, while when potentized they are readily absorbed also by unabraded membranes. Why should not potentized vaccine virus when administered by the mouth be as protective as the crude? I do not here speak of high potencies, but of triturations or dilutions below the 6th. Hahnemann used belladonna in a similar form for prophylactic purposes against scarlet fever, of which he speaks in his Lesser Writings, p. 232 of the German edition. He administered ~~432,000~~ of a drop of tincture, which corresponds to a little more than the 5th dec., with surprisingly good results. The advantage gained by such a procedure is apparent. The effect of potentized preparations upon the system will not be denied by any homeopathic physician. The *dangers* from such a dose are reduced to nothing. Introduction of disease product other than vaccine is impossible as long as we select for triturations a substance taken from an otherwise healthy calf. One such calf would give us enough vaccine to protect a million of people, and the excuse of vaccinators that not sufficient reliable vaccine can be produced to satisfy the demands falls flat.

The many disadvantages of the crude vaccine inoculation should at least induce all humane physicians to try the protective powers of potentized virus. Experimental vaccination after the introduction of the potentized product would be valuable, although not convincing unless reported in many cases; for we know that vaccine will "take" over and over again soon after it has run its course in the same individual. The same observation, if made after the administration of potentized vaccine, would have no weight against it. But even if the effect of vaccination is *modified* by the previously administered potentized vaccine, I think its beneficial effect has been demonstrated, because vaccination itself does not protect absolutely against the invasion of smallpox. As far as my personal experience

goes, I have never seen variola to occur in individuals to whom I had given the 3d of vaccinum or variolinum, even if they were in close proximity to smallpox. I have taken it myself when treating smallpox. I have given it to my children, who had been actually exposed to smallpox. I do not believe that there is any method in medicine that cannot be improved upon, and *I consider the administration of potentized vaccine an improvement upon the old method.* If anyone thinks it necessary to *inoculate* with the potentized virus instead of administering by the mouth there is no objection in doing so. That is an absolutely personal matter. But as long as the most ardent advocates of vaccination acknowledge; (a) That it does not protect for a lifetime; (b) That it does not protect in all cases; (c) That revaccination is necessary at longest every five years; (d) That revaccination becomes absolutely necessary at the outbreak of epidemics, disregarding previous vaccination; (e) That complications of various kinds, sometimes dangerous ones, are liable to arise at any time; (f) That serious chronic constitutional infection may be propagated by vaccination—then let us replace this method by one which guarantees the same prophylactic and modifying virtues at the outbreak of epidemics without adding complications and constitutional dangers. And as long as isolation and an absolute quarantine are the most radical means against the spread of epidemic smallpox, let these be the safeguards against infection, and the ideal means of stamping out all pestilences, leaving prophylactic protection for those who are overfearful of their health and of the disfigurement of their faces.



## THE TREATMENT OF SMALLPOX.

BY

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NEW YORK.

THE widespread *recrudescence* of smallpox has awakened general interest in the disease, and demands our attention as therapeutists. Smallpox is essentially a disease of children, like scarlet fever, diphtheria, and whooping cough. Like these also, sporadic cases of smallpox occur in individuals of all ages, even the very elderly; but when the disease is epidemic the vast majority of cases are in children, and its severity is usually in inverse proportion to age. This aphorism is subject, of course, to many exceptions.

Smallpox has shown itself this winter at various points throughout the United States and in a much larger number of cases than for some years. It is possible that we are on the eve of a great epidemic, although it is not probable that we shall see another really great epidemic this century. Like all diseases of this class, smallpox, though constantly present in isolated cases, comes in great waves, several minor epidemics being followed by a great one; after this there being a lull for some years. The interval between these epidemics has been steadily increasing for the past three hundred years. There has been a very notable decrease in the frequency of epidemics of smallpox since the second decade of the eighteenth century. Also, like all the exanthemata, these epidemics vary very greatly in intensity. In 1723 there was an epidemic in London, as we learn from the authorities of Christ's Hospital, in which the death rate was only one per cent. In 1791 an epidemic spread through the towns and villages of Gloucestershire, which was of so mild a character that a fatal instance was

scarcely ever heard of. Jenner speaking of this epidemic says: "The harmless manner in which it showed itself could not arise from any peculiarity either in the season or the weather, for I watched its progress upward of a year without perceiving any variation in its general appearance." And yet these were all unvaccinated cases.

All the contagious and infectious diseases diminish in intensity and virulence as the social and sanitary conditions change. All these diseases arise from bad habits of living, and as the conditions under which they came into existence disappear, they also tend to die out. Like volcanoes which are extremely active and destructive at first, but whose fires deaden down and break out at longer and longer intervals, until at last they are extinct, so the infectious diseases become less and less potent for evil with a betterment in social conditions. This is what happened with the plague, the black death, and many other epidemic disorders, and which is now happening with smallpox. While we may expect, when we take into consideration how many filthy communities there are in the world, to still have at lengthened intervals great epidemics, the progress of sanitation gives ground for hope that in the coming centuries they may be altogether prevented. Unfortunately, though these diseases may properly be classed as filthy diseases, they are not restricted to filthy people. A careless servant may set a great hotel on fire and endanger the lives of hundreds, and so a little nest of filthy people somewhere on the outskirts of a great city may furnish the necessary nidus in which smallpox may breed and, like a conflagration, spread throughout the town.

There is a tendency now for health boards to assume more and more authority over the profession. While there are many competent men in the *genus* political doctor, the local health boards and the State boards also, as a matter of fact, are not composed of men of superior intelligence and knowledge to the average physician; but it is human

nature to be fond of power, and just as soon as a man obtains a little official dignity he assumes to lord it over his brother. The health boards would gladly relieve us of all our patients if they could. Some years ago it was actually seriously discussed by the New York Health Board as to whether physicians could not be forced to give up their scarlet fever and diphtheria cases into the hands of the board, and now a general effort is being made to acquire as much authority over consumptive cases as the physicians and the community will stand, and this though it is well known that the segregation of any disease within limited quarters tends to increase its virulence.

It is very desirable that all physicians should know how to treat smallpox. The ordinary family physician can do a great deal better for the patient than the board of health, for the reason just stated that the gathering together of these patients in one place tends to increase the fierceness with which it consumes its victims. Vaccination has proven a delusion. In 1797 Jenner claimed to have introduced a method by which smallpox could be entirely annihilated, and for this the government gave him one hundred and fifty thousand dollars. Jenner at that time (1798) said: "What renders the cowpox virus so extremely singular is that the person who has been thus affected is forever after secure from the infection of the smallpox;" but twenty-three years later, that is, in 1821, Jenner was himself revaccinating his own patients every year; and it is now admitted by all vaccinists that whatever preventive power vaccination has against smallpox, the duration of such immunity is variable and unknown, but is probably not more than a year. However, many persons not only take smallpox soon after being vaccinated, that is, within a few weeks or a few months, but may die of it. Thus in the epidemic in Scotland in 1871-73 there died of smallpox 517 infants under one year of age, all of whom had been vaccinated. Evidently vaccination did not mitigate the attack in these 517 cases.

As vaccination, then, is at the best but an uncertain preventive, and as sporadic cases of smallpox are constantly occurring, it is desirable that every physician should know how to treat cases that fall into his hands. He is not doing justice by them if he permits them to be taken off to the pest house, because experience shows that the deaths in these cases amount to about sixty-five per cent., while the natural death rate from smallpox is about eighteen per cent. In the latter part of the eighteenth century before vaccination was introduced, and with the crude therapeutics then in vogue, the fatality of smallpox was about in the ratio of 1 to 6; that is to say, in 42,145 cases 7555 died, this being a death rate of 17.64. Even this death rate is higher than what occurred in many large epidemics. As, for instance, in 1752 one-third of the inhabitants of Boston, Mass., were attacked with smallpox. Of these 5545 cases there were 539 who died, or 9.7 per cent. It is evident, therefore, that when, in our modern pest house, death claims two out of every three victims of the disorder, there is something wrong in the management.

Smallpox is described in all the text-books as a hideous and disfiguring disease. This it undoubtedly is when treated improperly, but with adequate sanitary supervision and under efficient homeopathic treatment it is neither hideous nor disfiguring. The terrible and disgusting pictures of the disease, which writers upon practice of medicine copy one from another, are simply descriptions of what the disease was under the unsanitary and brutal treatment of a century or two ago. To put the patient into a hot room on a feather bed, with two fat and perspiring women on each side of him, the trio covered by another feather bed and the bed surrounded by red hangings, might indeed result in a hideous condition of the patient, but treated as we now know how to treat the disease it is less obnoxious than others that we meet almost daily. In fact, smallpox is not only less dangerous than either diphtheria or scarlatina,

but its sequelæ are less to be feared. The normal death rate of smallpox is about the same as that of pneumonia, and it is no more difficult to treat than erysipelas.

One of the first requisites in the treatment of smallpox is pure air and plenty of it. The patient should have an upper room on the sunny side of the house, with all hangings, carpets, and other woolen material removed. If the room can be warmed by an open grate fire so much the better, because this furnishes steady and adequate ventilation. The temperature of the room should be kept as near 70° Fahr. as possible, but this should be maintained by having plenty of heat and then permitting the entrance of fresh air, so that there may be a steady change of air throughout the room day and night. The light must be excluded from the room as much as possible in order to prevent marking of the skin, but the room should be situated on the sunny side of the house, so that at intervals during the day the patient may be entirely covered for a few moments and the sun allowed to shine into the room. Sunshine is the great disinfectant. All strong-smelling chemicals, such as chloride of lime and carbolic acid, should be excluded. They are not only unnecessary, but harmful, and while they may not be useless in some forms of disease, they have no relation to smallpox. There is, however, one chemical agent that can be used with advantage, and which should be used continuously from the time smallpox is suspected until the patient is able to leave his room, and this is the cyanide of potassium. I use this by having a saturated solution made, which consists of equal parts by weight of the cyanide and hot water. This I place in saucers, or other open vessels, in the room, and as the solution evaporates refill them day by day. It is also well in the height of the disease to spray, by means of a fine atomizer, a little of this solution, diluted by adding five parts of water, into the air and against the woodwork of the room. It produces no odor, or only a very slight odor

of prussic acid, but it acts as a complete disinfectant. With proper ventilation and the use of the cyanide of potassium the room is kept as sweet as if there were no sick person in it. The cyanide of potassium has been claimed to be a preventive of the disease. Dr. Korndorfer of Philadelphia noticed that in the epidemic of smallpox all mechanics who used the cyanide in their manipulations were exempt from the disease. However this may be, I know by actual experience that it thoroughly disinfects the smallpox patient's room without its own presence being perceived.

The patient's clothing should be changed daily, care of course being taken, as in all fevers, that the night dress, sheets, pillow slips, and whatever comes in contact with the patient's person have been thoroughly heated in the oven and are absolutely free from moisture before they are brought into the room. The removed clothing should be placed in a pail of boiling water brought into the room for the purpose, and nothing should be taken out of the patient's room, such as dishes, spoons, knives, glassware, etc., except by being submerged in a pail of boiling water and this carried to the kitchen. In this way there will be no danger of communicating the disease to anyone else in the house. This caution applies to the nurse's clothing as well.

The room, as I have said, should be kept at a comfortable temperature, so that the patient may not need an unnecessary amount of bedcovers. There are two reasons for this: First, the patient is more comfortable in a temperature of 70° Fahr., and is less likely to have bronchial complications when breathing regularly an even temperature; and second, there is also less danger of carrying the disease out of the room, because there is less bed material to handle. It should always be kept in mind that there are two things in treating all infectious diseases: (*a*) to secure the return of health to the patient, and (*b*) to prevent anyone else taking the disease. If doctors and others who wait upon the sick would insist

upon proper sanitary precautions disease would never be communicated from the sick to the well, provided the patient could be isolated. The only valid reason for at any time removing a patient from his own house is that its situation prevents proper sanitation; but in so removing him we should not forget that he has rights, and that it is proper that those rights should have first consideration. It may thus arise in many cases that it is better to remove the well than the sick. We have no right at any time to seriously endanger the life of a sick person for the benefit of well ones, for, as a rule, the other dwellers in the house can be sent away without harm resulting.

The diet of the smallpox patient should be simple and light, and such as is usually given to fever patients. He should be encouraged to take liquids, preferably water, but also any of the alkaline waters, such as vichy or seltzer, if he desires these, or lemonade, milk, soups, and gruels. These latter should all be plain and offered in small quantities, but at frequent intervals. Solid food should not be given to the patient until the pustules are well on the way to exsiccation, and should begin with the simplest articles, such as baked apples, farina, rice pudding, and food of like nature. The convalescent smallpox patient, like one from typhoid, has an enormous appetite, but this must be ministered unto with great caution, especially until after the time when the secondary fever occurs has completely passed. Even in confluent cases this secondary fever will never occur in severe proportions if the recommendations in this paper be carried out. This secondary fever is the fever of suppuration, and does not, strictly speaking, belong to the smallpox process. We can prevent it entirely by our homeopathic remedies, seconded by proper hygienic measures.

During the first stages of the disease the patient is apt to be restless, and he should be kept quiet by gentle but firm admonition. Rest in bed with as much sleep as quietness

in the room and all good conditions may permit is always desirable. The patient should be encouraged to sleep as much as possible. If the subjective symptoms are met by proper medication the patient will doze a large portion of the time during the febrile stage.

We now come to the medical treatment, and in this we have one of the great triumphs of homeopathy. In fact, there is no disease, not even pneumonia, in which homeopathy shows to such obvious advantage over old-school methods. It is a great pity that our homeopathic physicians have allowed themselves to be, to such a general extent, overborne by allopathic opinion, and have resorted to allopathic measures, or have given up their patients into the hands of allopathic boards of health and hospital authorities.

If the patient is seen in the earliest stage of the disease, that is, during the initial chill, it will be impossible to diagnose smallpox, and the patient should be prescribed for on the symptoms then present. I think in all cases I have given bryonia on seeing the patient during this prodromal period, but it might well be that other remedies would be called for in other cases. But the sudden rise of temperature, the nausea and vomiting, the insomnia, and the severe headache are very apt to closely resemble the bryonia picture.

On the second day, and thence on for several days, excruciating pain in the loins might well call attention to antimonium tartaricum; all this is previous to appearance of the eruption, which does not show itself until the third day. At the beginning of the eruption and during the height of the fever, that is, on the third, fourth, and fifth days, baptisia will usually be indicated. However, one should never prescribe for a smallpox patient, any more than any other, on general indications, but should make his prescription individual, so that it might well be that calcaria, or hydrastis, or phosphoric acid, or indeed any



remedy in the *materia medica*, might be homeopathic to the case. If the case is a severe one the temperature will probably have risen on the third or fourth day as high as  $104^{\circ}$  Fahr., or even to  $105.5^{\circ}$  Fahr., but unless complications arise there will be a sudden drop of temperature on the fifth day to the neighborhood of  $101^{\circ}$  Fahr. This reduction of temperature is a normal accompaniment of the evolution of the vesicle, and is independent of medicinal action. If the case has been properly treated so far the temperature instead of dropping to  $101^{\circ}$  Fahr., and then with oscillations advancing again by the eighth day to  $102^{\circ}$  Fahr., will now, as described in the text-books, drop to  $99^{\circ}$  Fahr., and will not again rise beyond  $99.5^{\circ}$  Fahr. I have seen some severe confluent cases, but I have never seen a case in which the temperature reached  $100^{\circ}$  Fahr. after the fourth day; that is, the second day of the eruption.

The value of variolinum in the treatment of smallpox, it seems to me, cannot be overestimated. Used in the 30th potency and beginning its use coincident with the change of the papule into a vesicle, it carries the case safely to a conclusion without any of those disfiguring conditions which are evidently so usual under allopathic practice. Exsiccation begins on the fifth day. The vesicles, which have protruded like peas scattered profusely over the surface of the skin, dry up completely and disappear. There is very slight swelling of the features, and this does not increase after the fourth day, and soon decreases and becomes unnoticeable. The vesicles do not rupture and there is no odor. In fact, variolinum has the same abortive influence in smallpox that baptisia has in typhoid, and I believe that under its use, even in confluent cases, the death rate would be almost nil.

Variolinum, vaccinium, and malandrium have all been spoken of highly in the treatment of smallpox. I have had no experience in the latter two remedies, having had

such satisfactory results from variolinum, which I use always in the 30th potency, that I have had no occasion to use anything else. Thuja and baptisia have been used in great epidemics by homeopathic physicians with success, and the pathogenesis of each of these drugs show the reason therefor. Doubtless individual idiosyncrasies might also indicate other remedies, still it must not be forgotten that smallpox is a specific disease, and in all of them usually give a single dose of sulphur 30th on every third or fourth day. I cannot be sure that it has any effect when so given, because it is almost impossible to prove a negative, but I am sure that my cases recover quickly, and lose all evidence of having been ill far sooner than cases otherwise treated, so I am inclined to think that sulphur so administered is helpful, nor have I ever had any reason to believe that it interfered with the action of the remedy more specifically given.

The popular dread of smallpox is partly due to the disfigurement which follows in so many cases. I do not believe that this is ever necessary where the case is properly treated. I can point to quite a number of cases where the disease was very severe, but in which now no one would be able to detect the slightest evidence that the person had ever had it. One of the great points to be observed is to prevent the action of light upon the skin. Light, especially direct sunlight, photographs the impression of the vesicle upon the rete mucosum, and although there may be no break in the smoothness of the skin, the person seen at a short distance looks as if pitted. This can be prevented if light is absolutely excluded. It is almost impossible to do this completely, and the patient on recovering will be more or less disfigured by brown spots the size of the vesicle. We have, however, a remedy for this in sepia. Sepia, in the 30th potency, given after the patient is up and able to be about, will completely remove these brown spots and leave the skin in the same

condition as before the disease. I have seen it do this in a number of cases—in one case in particular, where the disease had been semi-confluent in a boy nine years of age, a spoiled darling who could not be controlled. He would sit up in bed and play solitaire, with a flood of light in the room, and his mother let him. When he had recovered sufficiently to be out on the street he was covered on exposed parts with brown round patches, the size of the vesicles, so numerous that they almost touched each other. I thought him disfigured for life, but gave him sepiæ 30th, and within a week all the staining of the skin disappeared as if by magic. No one would now suppose he had ever had smallpox.

Pitting when it occurs is, of course, irremediable, but it ought never to occur. It occurs from the breaking of the vesicle, and this is done either by allowing them to burst from becoming so full of matter that they must, or else by the itching causing the patient to scratch them and so tear them open. This itching may be obviated by various means. Probably no one thing is adaptable to every case, but chemically pure glycerine is advantageous to most cases. In some the doubly refined or white vaseline acts better, and in still others the infusion of hydrastis. Other things might be needed in particular cases, but I have never had to go outside of this trio. It is absolutely essential to allay the itching in order to prevent pitting, otherwise the patient will scratch the vesicle when asleep, even though he has resolution to keep from it while awake. I have noticed also that the condition of the bowels has a good deal to do with skin irritation. If the bowels move freely and naturally there is less erythism. I therefore am very particular about the food of the patient, varying it so as to secure free movement, giving freely of liquids, and using stewed prunes, figs, New Orleans molasses, maple syrup, or other laxative foods. This soluble condition of the bowels is easily accomplished under homeopathic treat-

ment, because there is no high fever after the first two days of the eruption to dry out the watery constituent of the fæces and so cause constipation. Absolute cleanliness also aids very much in preventing skin irritation.

As soon as the vesicles have dried up and the scabs begin to exfoliate I exercise great caution in preventing this matter from being distributed by keeping the patient scrupulously clean, and using every morning over the entire surface of the body some oleaginous substance, such, for instance, as fresh lard, and washing this off with a plentiful supply of hot suds. In recent years I have used for this purpose Woodbury's facial soap, which contains a small amount of mercuric chloride, but I do not know as this is necessary.

As to the value of variolinum as a preventive of smallpox, I cannot say much. It is advised by some homeopathic physicians as internal vaccination. I can only say that while personally very susceptible to all the exanthemata, I have been a number of times exposed to smallpox, remaining in the room with one or two patients for an hour or two at a time, and in personal contact with them, and yet have never taken the disease; nor in any case has the disease spread from the case being treated to other members of the family. This is negative testimony, but the tests in regard to vaccination are also negative. The person is vaccinated and does not take smallpox, therefore it is said that vaccination prevented smallpox. I give variolinum internally and the persons do not take smallpox, therefore it may be said with equal truth that variolinum prevented smallpox.

Variolinum in the 30th potency is certainly a remedy of some power. Dr. J. P. Dake has recently stated that triturated vaccine matter (variolinum) is dead and disintegrated vaccine germs, and that it is incapable of preventing smallpox. Now I know, by personal experience, that variolinum in the 30th trituration will produce both

subjective and objective symptoms resembling smallpox. I have been told by physicians who have administered it to healthy persons that it has caused pustulation. I have never myself seen pustules develop, but I have seen an erythema similar to that which precedes pustulation in severe cases of smallpox. This erythema in a number of cases where I have administered variolinum to healthy persons has been very pronounced, being particularly noticeable upon the chest, on the sides of the body, and on the inner surface of the thighs, but also observable on the face, on the back, on the hands, and on other portions of the body. This was accompanied with intense itching and the peculiar characteristic of the eruption of smallpox just before the pustule forms. Associated with this was a decided rise of temperature, in one case the thermometer marking  $101^{\circ}$  Fahr. There were pains in the head and back, nausea, and other symptoms of the initial stage. More than this, variolinum so given seems to extinguish the susceptibility of the system to smallpox, for if given again two weeks afterward it produces no result whatever.

THE PREPARATORY TREATMENT FOR AB-  
DOMINAL OPERATIONS.\*

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THE present status of abdominal surgery does not call for much discussion of methods, and scarcely for the report of cases, unless they possess features of especial interest. For while I believe that operations upon this region of the body should be confined to specialists, at present almost every surgeon seeks to increase the number of his laparotomies, and even though inexperienced in this department of surgery, undertakes with courage, and sometimes with success, the most difficult manipulations, and then publishes his work, even to the most minute detail, for the benefit of the profession. But the method and length of the incision, the ligatures and their application, the drainage of the abdominal cavity, *pro* and *con*, the toilet of the peritoneum, have all been discussed and practically settled; that is to say, such points in technique are recognized as entirely subordinate to the experience of the operator, and are determined at the time of the operation by unconscious cerebration on his part.

Those of us who have done much abdominal work, who have met with its various forms, and who have conquered its most fearful complication—I use the word advisedly, for I know of nothing more fearful than a complicated laparotomy—feel that each case must stand by itself and be treated as such, and that we cannot reduce an abdominal operation to a mathematical problem.

I believe that no surgeon should attempt abdominal

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surgery until he has had a large experience in general operating, for here the manipulations combine the technical skill, the boldness of undertaking, the delicacy of touch of operative surgery generally, and these essentials to success should be acquired in operating upon organs less essential to life than those in the abdomen.

For these reasons, and because of the existing voluminous literature on the subject, I consider, as I have already said, that a discussion of methods in abdominal surgery can at present be of little avail. I will, however, ask you to consider "the preparatory treatment for abdominal operations," a question that I think has suffered neglect because of the attention given to the more attractive and certainly more brilliant details of the operation itself.

The term as I have used it may be misleading when regard is had to the principle upon which is based the preparatory treatment I advocate, viz., the encouragement and maintenance of organic activity, especially of the eliminating organs.

In the first place, I am convinced of the truth which I had impressed upon me by the late Sir Andrew Clark, that diseased organs and parts do not require rest in order to recuperate. In other words, health and disease have this in common: that in order to retain one, and remove the other, the physiological law of action must be observed. Hence my preparation of patients for laparotomy is not of such a nature as to arrest organic activity after the operation, but is rather in the line of maintaining such activity, or possibly stimulating it for a few days.

One of the first and most constant effects of ether, and especially of abdominal operations, is congestion of the kidneys, and hence failure to eliminate waste and harmful elements from the blood. I therefore am in the habit of prescribing some mild diuretic, preferably Poland water, for several days prior to the operation. Since adopting this practice I have seen none of the scanty urine usual

after a laparotomy. In place of the quantity being reduced to ten or twelve ounces in the first twenty-four hours, my patients void almost the usual amount. Neither do I under this treatment observe the urinary tenesmus, and urethral irritability, that formerly proved so painful and troublesome a feature of the after treatment of abdominal operations.

This, however, is probably the result of a combination of causes: First. But very little ether is used, for my most difficult and complicated abdominal hysterectomies rarely last over thirty minutes; my usual time for an ovariectomy, or double oöphorectomy being ten minutes.

Second. For several days before the operation I place my patient on an animal diet, and thus avoid fermentation and the consequent formation of gas that is very apt to follow farinaceous food. I also, as far as possible, avoid milk, as tending to constipate.

And here I reach another important point in the preparatory treatment, illustrating my belief in the advantages gained from encouraging organic activity. I refer to the attention given to the intestinal canal, which accomplishes the twofold object of clearing it of its contents, and at the same time establishing an antiseptic state of the intestine. By freeing the bowel of its waste material we not only favor activity, but we remove an important element in the causation of stasis of the intestinal circulation, both of the lymph stream and the blood stream, and thereby favor a degree of activity which cannot fail to be of advantage in restoring pelvic circulation, and preventing or greatly modifying peritonitis, should such develop. This clearing and cleansing of the digestive tract accomplishes more: it to a great extent controls the formation of gas, one of the most troublesome conditions with which the after treatment of abdominal operations is attended, and such quantities as do form cause less suffering and are discharged more freely.

I am also very partial to having the liver gently active—



as the majority of women suffer from torpidity of this organ—knowing as we do the unrivaled power to destroy morbid products which the liver and its secretion possess. A few doses of *mercur. dulc.* will accomplish this, and usually compound licorice powder will be all that the intestines require, while naphthaline, given in 5-grain tablets for several days, renders the canal as nearly as possible antiseptic.

As an excretory organ, the skin also receives attention. If consistent with the conditions and circumstances of the case, I favor a Turkish bath, taken not less than three days before the operation, to be followed by daily baths. After the operation my nurses are instructed to give frequent sponge baths. By this means the skin is kept functionally active.

Next the heart calls for attention. This organ probably less than any other comes within the category of those requiring preparatory treatment. It, however, is not wholly exempt. The drain upon the nervous system of an abdominal operation is frequently severe, and shows itself in rapid action of the heart, which, unless caused by pyrexia, means nothing less than exhaustion, and in a sense diminished strength. In modern times more laparotomies succumb to heart failure than to peritonitis, for I think the latter, unless in cases of suppuration, is entirely avoidable, while the former is, at least at present, less under control.

If there is a weak action of the heart, or if the constitution suggests that such a condition may be developed by the operation, I order a few drops of digitalis and opium. I fancy that the mixture acts more favorably than digitalis alone, and I do not recall a case in which the heart has given serious trouble when I have adopted this preventive treatment.

Occasionally, when I have thought the heart weakness due wholly to nervous origin, I have substituted strychnine for the digitalis and opium, but I have found the latter

mixture more frequently called for, and as nearly as I can judge, to give the best results in the preparatory treatment for abdominal operations.

A last word concerning the anæsthetic, and the use of morphine, and their effect upon the after course of the operation.

The general rule, that ether is better for persons in middle life, and that chloroform is more adapted to youth and old age, I have considered a safe guide, unless some strong contra-indications exist. These will relate principally to the condition of the kidneys, the heart, and the bronchial tubes. If the kidneys show evidence of congestion or faulty secretion, or if there is bronchitis, I decide against ether. If, on the other hand, the heart is organically weak I exclude chloroform. In all my practice I have never had a fatal result that could be attributed to the anæsthetic. And I have yet to meet the individual to whom, being otherwise a proper subject for an operation, I would refuse to administer an anæsthetic.

For ether I use the "Clover inhaler," for the reason that with it the anæsthetic can be forced, and after that a state of perfect relaxation maintained with the minimum quantity of ether. For chloroform I use "Esmarch's" apparatus, but this is only for convenience, as a folded handkerchief will answer equally well, if the respiration and state of the pupils are watched.

My early surgical training, especially with English surgeons, led me to look unfavorably upon the use of morphine to control pain after abdominal operations, but my own later experience has greatly modified my opinion and practice in this regard. Undoubtedly morphine, when used continuously, does cause intestinal paresis, and when so administered does not meet with my approval; but, save in extreme cases of suffering, we are not obliged to use it in such doses as to interfere with the functional activity of the intestine. Then we must remember that morphine is

one of our most valuable drugs to overcome the nervous exhaustion that accompanies shock. For the first twenty-four hours following a laparotomy there is usually considerable pelvic pain—especially I have observed this when the appendages are removed—sometimes amounting to actual agony. I believe it is injurious to the patient to endure this without assistance, and therefore, as I know of no “similar” remedy that affords the necessary relief, while it is not a routine practice with me, my house surgeon, or my nurses who have nursed for me long enough to be trusted, are instructed to give a hypodermic of one-quarter grain of morphine, and to repeat it in one-sixth-grain doses until the patient is quiet. Usually the first hypodermic gives the necessary relief, but I find a grain is well borne in the first twenty-four hours. After this it is rare that patients require morphine. If they do they get it. I have never observed any ill effects from this judicious use of the drug, and frequently my patients go through convalescence with no other medicine than a quarter of a grain of morphine the night of the operation.

It will thus be seen that the object I seek in the preparatory treatment for abdominal operations is to encourage organic activity, not to arrest it. All the organs that eliminate are acted upon. The kidneys, liver, intestines, stomach, heart, and skin are placed in a healthy state, and thereby encouraged to perform their several functions.

To this preparatory treatment, quite as much as to the facility of operating that comes only with experience, I attribute my success in this department of surgery.

## THE EMERGENCIES OF ANÆSTHESIA.

BY

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ONE approaches the subject of anæsthesia and anæsthetics with a feeling of certainty as regards the knowledge one has of the subject, especially if large experience in a great number of cases for a long period of time can be depended upon as a reference and support.

Upon examination of the literature of the subject, however, than which there is none more voluminous, a marked element of uncertainty will enter into the supposed well-grounded conclusions, and the result is liable to be a condition of doubt and perplexity. An anæsthetic may be administered many, many times by a novice with no serious complication to call for anxiety or special treatment, and this would ordinarily in any other department of surgery or medicine warrant the tyro in concluding that the fear of using anæsthetics was a bugbear which his experience decidedly disproved. There comes a time, however, when a patient that is to all appearances in fit condition to be subjected to anæsthesia proves to be "a bad case," and the decision of the inexperienced user will be altogether reversed. Strange as it may appear, the authorities on the subject are as much at variance with each other as are the two above-mentioned conclusions.

Up to the time of the formation of the Hyderabad Commission a man's individual opinion formed alone by his personal experience was the guide which governed his selection and administration of an anæsthetic; the textbooks varied in their recommendations, and the surgical experts of different nations—and even of not widely separated portions of the same country—had their favorite drug for producing unconsciousness during operation.

In 1888 it was thought that the above-mentioned commission, experimenting in India, a country in which there are no restrictions upon investigation with animals, would finally settle the vexed question of the danger attending the use of chloroform as an anæsthetic at least, and forever set at rest the queries of what vital function of the economy is first and most dangerously attacked when the subject succumbs to the administration of the drug.

The commission was formed by the generosity and love of science of the Nizam of Hyderabad, an Eastern potentate, and reported, after killing 141 dogs by chloroform inhalation, that "it is impossible for chloroform vapor to kill dogs by acting primarily on the heart, and this holds good no matter in what doses or in what manner the poisoning is introduced."

This statement gave rise to so much adverse criticism that a second commission was formed by the same patron, which experimented upon six hundred more animals, mostly dogs, to determine which physiological function, respiration or circulation, was affected most by the inhalation, and especially to determine which function ceased first.

After carefully watching the development of symptoms, and the gradual cessation of all functions, it was said to be the case that the respiration invariably ceased before the heart stopped beating. This latter conclusion caused a perfect storm of criticism and disapproval, expressed in the journals of 1890, among the more valuable of which are one by the eminent therapists Drs. Wood and Hare in the *Medical News* of February 22, 1890, and another by Dr. J. C. Reeve in the same journal for October 18, 1890.

The latter writer, after criticising the commission for attempting to make the results of the experiments tally with a preconceived theory instead of reporting from an absolutely independent standpoint, contends that the reports of fatal cases following chloroform administration warrant us in believing that four forms of death present themselves to the clinical observer, viz.:

I. Sudden death during struggling or excitement, in which it is difficult to say just where the process commences. There is great excitement of the nervous system, tetanic contractions of the muscles of the chest, with suspended respiration, followed by very deep inspirations and sometimes general convulsions. The frequency with which death has occurred at this part of the inhalation marks it as the most dangerous stage of the process.

II. Death by paralysis of the respiratory center, the heart having been observed to continue beating after respiration has ceased. Ten deaths occurred in this way out of forty carefully observed cases.

III. Death by paralysis of the cardiac centers. The pulse fails, the divided vessels suddenly stop bleeding, the heart ceases to act, while respiration has been observed to continue for some time.

IV. Death by simultaneous cessation of respiration and heart action.

Now as to the number of cases to be carefully observed before one is entitled to make a positive statement, it is said that 28,000 administrations of chloroform were made in one corps of the Confederate army in the Civil War without a single death that could be directly attributed to the drug. The celebrated Southern surgeon Dr. Hunter Maguire of Richmond, Va., president of the American Medical Association, had 15,000 successful administrations and then a death attributable to the use of chloroform. An English hospital, however, had 1 death in 200 administrations. Surgeon-Major Lawrie of the English army, head of the Hyderabad Commission, has had the enormous experience of about 40,000 administrations without a death, and claims that the immunity is due only to carefully "watching the respiration."

We are all familiar with the old idea that chloroform death ensued from paralysis of the heart, and that ether death depended upon respiratory paralysis.

The commission also reports that "the anæsthetic should never, under any circumstances, be pushed till the respiration stops," and Lawrie declares that there is no danger if the administration is "stopped directly the state of the cornea shows that the patient is under."

Reeve here also takes occasion to point out that the position of the commission is not secure, for, as he states, about fifty per cent. of the deaths from chloroform have taken place before the stage of complete anæsthesia has been reached. Some of them have occurred at the very beginning of the administration, after an inhalation of only a few seconds. Within so short a space of time as that death occurred in four of Snow's fifty cases, and in five more it took place within a minute.

The last and most important doctrine of the commission is that there is no doubt whatever [to quote] that if the above rules be followed, chloroform may be given in any case requiring an operation with perfect ease and absolute safety.

On this statement Dr. Reeve comments thus: The only new rules laid down, it will have been observed, are the one positive, that the respiration alone should be watched, and the one negative, that the pulse should not be watched. The inference from this position of the commission is that all deaths have been the results of bad administration. Surgeon Lawrie does not avoid the issue. "There is no danger when the chloroform is properly administered," is his statement. It is against this doctrine and its corollary, so untenable in the light of clinical experience, so dangerous to patients, so momentous in their bearing upon the conscience and the material interests of the profession, that I most solemnly and earnestly protest. It is but just that when a man loses a patient under an anæsthetic he should be required to show that due care was observed and all precautions taken; but to hold that the death is *prima facie* evidence of want of skill or careless-

ness is a monstrous doctrine. See where it carries us—to the unavoidable conclusion that many of the best surgeons of the world have caused deaths that might have been avoided ; and that men who lead in the study of this subject, who have devoted their lives to it, did not know how to administer the remedy properly. Simpson and Snow and Clover and Kappeler, all had deaths—therefore they violated the rules of safe administration. I protest, in the interest of patients, against the doctrine that chloroform can be administered with absolute safety. If this procedure is to be looked upon as no more dangerous than giving a drink of whisky and water, as has already been claimed, there will be a more frequent recourse to it, and lives will be sacrificed in consequence. The doctrine cannot be accepted without ignoring a vast amount of evidence, both experimental and clinical—evidence which outweighs all theories and all doctrines, no matter whose names may be appended to them.

I have purposely quoted somewhat at length from the Hyderabad Commission's report, and the criticism of the same by Dr. Reeve, to show that there is now among the most earnest and careful investigators a considerable amount of doubt as to the effect of chloroform upon the human subject when bad symptoms attend its administration. My personal experience with chloroform is not worth serious consideration or report on account of the comparatively small number of cases in which it has been administered under my direction or by myself. Suffice it to say that no emergencies occurred in the cases, and the patients recovered without complication, so far as I know, which could be referred to the remedy.

It is without doubt—as will be shown later—a more dangerous anæsthetic than ether, but certain contingencies demand its use ; among these may be mentioned operations about the face in which it may be necessary to use the thermo-cautery—which would be rendered impossible if the



inflammable ether was administered—certain diseased conditions of the kidneys which ether is supposed to seriously influence, and in operations upon the brain in which the meninges are liable to be congested by the other anæsthetic. (Horsley.)

A patient will occasionally—but rarely—be met in whom it is quite impossible to produce complete anæsthesia with ether, and in which a few inhalations of chloroform will render the subject amenable to the ether when applied the second time. This, it seems to me, is especially the case in old “alcoholics,” whose systems are impervious to anything but the most rigid treatment.

There is one question which I have diligently sought for in the literature of this subject, without success, but it is one that I have considered many times, viz., Why is it not possible for an apparently healthy person to meet with sudden death during anæsthesia which could not be foreseen or provided against?

We know that a comparatively large number of the race dies suddenly when in apparently the best physical condition possible—one has an atheromatous spot in one of the cerebral vessels, another an ossification of the coronary arteries, another still a formation of a clot which, carried to the heart, produces paralysis of that organ, and there is a large number in which the lamp of life simply burns low and goes out without a flutter to announce the end.

In these thousands upon thousands of cases that are reported with but a very, very small percentage of deaths, is it too much to claim that a certain proportion of these, at least, may have been brought about by some other cause than the anæsthetic itself? Many cases are reported in which no *post-mortem* examination was made, and this is prominently brought to mind in the case which was so widely discussed but a short time ago throughout the country on account of the prominence of the unfortunate gentleman who succumbed to the anæsthetic.

Kappeler, a most eminent authority, states most plainly that "ether death does not differ materially from chloroform death," and Dr. Reeve—above quoted—states in Holmes' "Surgery" that "ether in the human subject may cause death as suddenly, or unexpectedly, and in the identical manner that chloroform does." Clinical proof of this statement was drawn out by criticism and appeared in the *Medical News* of January 22, 1887.

Dr. Reeve then goes on to say, "As this work was mentioned at the late International Congress and the proof accepted by Professor H. C. Wood in his address, it is presumed that the fact will be hereafter generally accepted. The truth is evident that the results obtained by experiment on animals cannot be absolutely and universally applied to man, and it is astonishing that men claiming to be scientists should presume to make such application. It utterly breaks down before such potent facts that dogs may be killed by elaterium without being purged, that pigeons bear enormous doses of morphine, and that goats and rabbits eat belladonna with impunity."

Another quotation worthy of consideration is as follows: "Carefully reading over the fifteen paragraphs in which these conclusions are given, it is surprising how many of the conclusions were well known to the profession long before, and which are therefore neither new nor necessary. It did not need a commission to tell us that the recumbent position is necessary for safety—the danger of any other has long been recognized. It certainly was unnecessary to tell us that the respiration should be free and unembarrassed. A tyro in physiology would recognize that in a patient to whom respiration and circulation alone remained of life, any interference with breathing, as by resting on the chest to restrain struggling, or by shutting out the air with an impervious towel, would be highly dangerous. This danger has been recognized and warning was given far back and all along in the history of anæsthetics."

The commission after mature deliberation stated in the report that death from chloroform was always dependent upon failure of the respiratory function, and that "the utmost attention to the respiration is necessary to prevent asphyxia or an overdose."

Another section declares that "the administrator should be guided as to the effect *entirely* by the respiration. His only object while producing anæsthesia is to see that the respiration is not interfered with."

Surgeon Lawrie boldly states that "the pulse is of no value as a sign of approaching danger." In support of this theory it is stated that "pallor and loss of pulse do not indicate that chloroform has any direct effect upon the heart, but that it has been given in such a way as to interfere with the breathing"; and "if part of the chloroformist's attention is to be directed to the pulse, an important element of danger comes into the administration." (Chief of Commission Lawrie, *Lancet*, June 21, 1891.)

These views of the commission, of which Surgeon Lawrie was president and Launder Brunton an added member for the second sitting of the same, were unanimously indorsed and individually defended by the commission from first to last.

These doctrines have been vigorously attacked by various writers, but by none with more force than Dr. Reeve, who adduces reports of cases by Snow, Anstie, and Dawson, and makes a clinical report of three cases by Kappeler from his *Anæsthetics* of 1880—in all of which instances were noted in which the respiration continued after the heart had ceased to beat, and in many of which it was recorded that a sudden change in the countenance took place, marked by extreme pallor and later by cessation of the heart beat, followed by gradual inefficiency of the respiration, which finally in a small proportion of cases ended in death, and in many others would have terminated in a like manner were it not for vigorous treatment beginning at once.

This pallor has been so marked as to excite considerable comment by the different authorities, and thus received a high place in the list of symptoms that mark the danger line of anæsthesia.

I think that none of us will belittle this symptom, which Kappeler thinks of the utmost importance and dignifies by the following description, which is certainly graphic enough: "Without warning, generally, also, without disturbance of the respiration, the countenance takes on a waxen hue, as if under the stroke of a magic wand; the lineaments are decomposed, the cornea loses its luster, and the fully dilated pupils become motionless; the jaw falls; at the same time the radial pulse ceases, and the heart sounds are imperceptible or extraordinarily weak; the open arteries cease bleeding. With cessation of the heart's action the respiratory movements terminate without cyanosis or dyspnœa, or a few sighing and spasmodic inspirations continue after the heart has ceased to beat."

The *suddenness* of death in a large proportion of the reported cases cannot but be remarked, and some authorities claim this as testimony that the heart instead of the lungs was the organ primarily affected. The commission further declared that deaths from chloroform are always due to an "over-dose." Surgeon Lawrie in the *Lancet*, June 21, 1891, says that "death from chloroform is always due to an overdose."

Dr. Reeve again takes exception to this, and inquires: "What is an overdose of chloroform?" He then answers the interrogation by the following: "Evidently when the patient inspires air carrying more than a certain small amount of chloroform vapor. Sudden death frequently occurs in animals breathing a supercharged atmosphere, and in man it has often followed a single deep inspiration. The necessity of care to avoid this danger is plainly stated by the commission. But this is not new. The danger of charging air with more than a small percentage of chloro-

form has long been recognized. It was taught by Snow, who believed that safety would be assured if the amount of vapor was kept down to four or five per cent. This doctrine underlies and sustains the use of all inhalers—instruments which mechanically prevent the presence of more than a certain amount of vapor. But it has not stood the test of clinical experience; death has occurred with all sorts of inhalers, even in the hands of the inventors who have vaunted their efficiency."

The "emergencies" of ether anæsthesia proper are not so many nor so dangerous in the hands of a competent anæsthetist as may sometimes appear. If the respiratory tract is kept well open and the breathing carefully watched, there will rarely be, nor has there been in my somewhat limited experience, any cause for alarm or special treatment.

A case of ether death pure and simple has never come under my observation, and many of those which have been reported I have often ascribed to other causes—not doubting the honesty of the recorder, but differing in some of the conclusions drawn.

In some cases the patients will refuse to breathe, but the cause will ordinarily be found to be an occlusion of the air passages, which elevation of the jaw will usually relieve, but which in some instances may go on to such an extent as to require that artificial respiration be induced. The hypodermic injection of brandy or ether, hot compresses over the præcordia, and, as latterly advised, injections of hot water into the bowel, with the other methods ordinarily used to produce resuscitation, are the means upon which we may depend for success; and cases are on record in which it has seemed impossible to revive the patient that finally repaid the seemingly hopeless efforts and saved a life.

In the first stage of anæsthesia the desideratum is to give the subject a sufficient amount of the ether vapor in

continuous doses, which are cumulative, but not sudden in their growth, for in many patients a resistance and strangling respiration will complicate the administration of the anæsthetic. A small amount of ether will cause an irritation of the bronchi and an accumulation of mucus; and it is often noticeable that the danger decreases as the patient becomes thoroughly etherized.

In watching the patient during etherization I have made use of a little aphorism that seems, in my experience, to fit the case, and that is: For danger attending the administration of ether watch the respiration; for the dangers consequent to the manipulations of the surgeon watch the pulse. In closing my part of the subject under consideration I can do no better than to transcribe a number of "practical conclusions" arrived at by Professor H. C. Wood, and presented in his address to the International Congress, the words of which are as follows:

1. The use of any anæsthetic is attended with an appreciable risk, and no care will prevent an occasional loss of life.

2. Chloroform acts much more promptly and much more powerfully than ether both upon the respiratory centers and upon the heart.

3. The action of chloroform is much more persistent and permanent than that of ether.

4. Chloroform is capable of causing death either by primarily arresting the respiration or by primarily stopping the heart, but commonly [sometimes] both respiratory and cardiac functions are abolished at about the same time.

5. Ether usually acts very much more powerfully upon the respiration than upon the circulation, but occasionally, and especially when the heart is feeble, ether is capable of acting as a cardiac paralyzant, and may produce death at a time when the respirations are fully maintained.

6. Chloroform kills, as near as can be made out, proportionately four or five times as frequently as does ether.

## A CASE OF FALSE CONCEPTION.\*

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BY

M. W. VAN DENBURG, A. M., M. D.,

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MRS. B., thirty-five, strong, well, and the mother of five children, had progressed as usual in a pregnancy until the end of the third month. At this time without any warning or cause, unless it might have originated in a prolonged hot bath, she noted a pink fluid discharge, and felt some abdominal pain.

At a call made two or three hours after the first discharge was observed the patient was put to bed, and as quite severe uterine pains had set in, a half grain of morphia was administered, followed by half-dram doses of viburnum prunifol., repeated every hour.

The pains were quieted by the morphia, and did not return for three days. On the night of the fourth they set in again, and in the middle of the night a small mass was passed per vaginam. On inspecting this the next day a piece of firm fleshy substance, about two inches by three, and from a quarter to a half inch thick, was found. In addition to this a closed sac fully distended by a limpid pinkish fluid was also found. This sac was not more than an inch and a quarter in diameter, roughened, shaggy on one side and very transparent on the other. In fine, it looked like the membranes and amniotic fluid of a three or four weeks' pregnancy. The transparency of the thinner side admitted to a perfect inspection of the contents by transmitted light. The most careful examination of this kind, conducted in a strong light under the most favorable circumstances, failed

\* Presented at the New York State Homeopathic Society meeting at Albany, February 13, 1894.

to reveal anything whatsoever except the limpid fluid described. No sign or trace of a fetus was to be observed.

In the subsequent preservation in alcohol the transparent membrane has become opaque; but the unruptured sac is now presented for your inspection. The fleshy mass is also in the same flask. On one side it seems to have a serous or mucous surface, on the other a shaggy, torn surface, and is constricted in the middle, causing several folds on the mucous surface. It can hardly be called a placenta, for there is no funis.

The sac can hardly be called a three months' ovum, for there is no trace of a funis or fetus within.

This woman had never had a miscarriage, unless a five weeks' delay of the menses, three years ago, was such an event. At that time she flowed very profusely and for a longer period than usual. At other times she has been "regular to a day," as she says, all her menstrual life.

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## PUERPERAL CONVULSIONS.

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BY

GEORGE LOGAN, M. D.,  
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MRS. W., primipara, aged thirty-five years, healthy. though there is some tuberculosis in her family record. Never felt better than during her pregnancy. I was called in to see her on the evening of the 17th of July, 1892. On examination I found the presentation normal, but as the labor was not far advanced I returned to my office, directing that if required during the night to send for me. About 6 A. M. was sent for, and when I arrived there I found the child was born, and after attending to the remainder of her labor I again returned to my office.



About 9 A. M., or three hours after delivery, her husband came to my office in great alarm, stating that his wife was in convulsions. As her residence was only two blocks from my office, I got there in a few minutes and realized that I had a severe case of eclampsia to contend with; was told that she complained of severe headache and pain in the stomach previous to the convulsions; found that the urine was scanty and highly charged with albumen; pulse full and rapid, face puffed, lips blue, and respiration somewhat labored, with other symptoms only too well known to those who have had experience in such cases.

I at once administered 9 drops of ext. verat. viride, then after waiting nearly one hour I dissolved 20 drops in half a cupful of water, and gave two teaspoonfuls every fifteen minutes, until the pulse became somewhat softer, the convulsions occurring each hour.

I found the remedy did not lessen the frequency of the convulsions, though it lessened somewhat the blood pressure on the brain.

I gave chloroform carefully from time to time, and during the fits protected the tongue by covering the handle of a tooth brush with some cotton and inserting it between the teeth.

The verat. viride was continued as the pulse and the other symptoms indicated.

About twelve o'clock I began to get a little fatigued, and sent for Dr. Baptie, an allopathic physician and friend of my own. He kindly relieved me and carried on the same treatment until toward night, each relieving the other once an hour or so. The convulsions returning regularly each hour, the vital power gradually lessening until she became comatose; respiration more difficult; deglutition impossible; the veratrum was now of course omitted.

Dr. Baptie suggested a hypodermic injection of morphine, to which I consented; this, however, did not lessen the frequency of the attacks. The case became more and more

desperate, action of the heart getting weaker, respiration stertorous, lungs congested, and altogether the case looked hopeless; still we toiled on during that long and dreary night with chloroform and a second injection of morphine, until we thought it was useless to make any further effort to save her life. It has been said that "when matters get to the worst they sometimes mend."

About five o'clock in the morning the convulsions ceased, there having been twenty in all.

In a day or two she gradually returned to consciousness; after a week the urine cleared up under the action of mer. corr. 5. Subsequently an abscess formed in the right lung which was discharged by expectoration, the latter being remarkably offensive, the whole body giving off a very fetid odor. She was given carbo veg. 200 for the abscess, and now at this date, November 14, 1892, is in fair health.

It will be observed that there is nothing new or peculiar about the above case; it is the last of six cases in all which have occurred in my practice of over thirty years—with one death. My other cases were *ante-partum*. Various remedies and dilutions were used: bell., hyos., gels., opium, and others as apparently indicated, with little or no appreciable effect; possibly they might not have recovered without. The convulsions in all cases, however, did not cease until after the uterus was emptied of its contents by forceps or by podalic version.

As a homeopathist I have to confess my regret at this unsatisfactory treatment of the above case, and also in all the other cases treated; notwithstanding the fact that I have lost but one. We should be able to do better than this, and in order that others more skillful than I can claim to be may be able to teach me better things, I shall feel truly thankful for any information on this, the "opprobrium medicorum" of our profession. I would suggest a symposium on the treatment of this disease by some of our

most experienced men who, having attended a larger number of cases, are therefore better able to manage this dreaded disease. They might perhaps dispense with the ætiology, pathology, physiology, and differentiation of this disease, and give us their individual experience in the treatment or means used, with any or all dilutions, high or low, of our remedies.

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### VESICO-VAGINAL FISTULÆ — PREPARATORY TREATMENT IN CASES OF LONG STANDING.

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BY

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THE cause, the means of preventing, and the various methods of closing these fistulæ are so well known that I purposely omit reference to any or all of them.

It is not of fistulæ of recent origin that I shall speak, but those cases of years' standing, where the bladder can no longer be designated as such, where the walls are thickened, where the cavity is so small that a mere *pipe* or *tube* remains, through which the urine passes unaided, its walls long since having lost their function.

Many of these cases (and, I am sorry to say, there are too many) are but the result of the injudicious, often unwarranted, efforts of the enthusiastic surgeon to cure a cystitis; in which he is not only rarely successful, but usually adds to the already distressing disease a vaginitis, as well as an inflammation of the external genitals, to say nothing of the inconvenience, the annoyance, and the pain caused by scalding urine. There has been no bag, box, or other apparatus yet devised which is non-irritating, or which can be adjusted to all cases.

A bladder which has not been called upon to perform its functions for many years, and whose cavity at most (due to the thickened walls, etc.) has a capacity for, say, half an ounce of urine, and not even the power to expel it, would not only be useless if closed, but its contents would remain in this tube and would consequently decompose, and thus act as an irritant, exciting a cystitis which would be relieved by immediately *re-opening* and *re-establishing* the fistulæ.

All this has occurred four times within my own knowledge, and I doubt not that others have experienced similar consequences in cases due to cystitis, the bladder being in similar condition; which condition is the rule, not the exception.

I believe that the only way to be sure of a successful result is, first, to be certain that there is a bladder, healthy and capable of performing its functions. The walls should be of normal thickness, capable of contracting and expanding under its normal stimulus, and of expelling its contents. This condition can and should be brought about by the proper *preparatory* treatment before ever attempting to permanently close the fistulous opening.

My method, which I first applied six years ago, was, first, to close the opening by artificial means, then to force water through the urethra. An instrument which I made (and which can be adjusted to all cases) closes the opening and exerts pressure on the anterior vaginal wall, while with the hands you effect counterpressure on abdominal wall. This causes lateral distention of vesical walls, and should be repeated from one to five times a day.

The whole procedure is simple, and in from one to four or six months the patient who has been a sufferer for many years could (if prepared in this manner), with the opening temporarily closed with the instrument, urinate as before the fistulæ occurred. After treating the bladder in this manner the operation for permanently closing the fistulæ can now take place with every assurance of success.

In addition to forcible distention I applied electricity, both galvanic and faradic currents.

I inserted sponges sufficient to fill the cavity of the bladder, closed the fistulous opening with the instrument, then forced water through the urethra; by so doing all parts of the vesical walls were brought into contact with the wet and swollen sponges and were acted upon by the electricity, which agent I believe assisted in stimulating the nerves and restoring the circulation.

The second case was not due to cystitis, but to prolonged pressure of fetal head. The condition (*i. e.*, the thickening of walls, etc.) of all cases were similar.

I omitted reference to cases of recent origin, because in these cases the vesical walls are normal, and success is the rule and not the exception if the operator is ordinarily skillful and careful in freshening the edges, applying the sutures, etc., except, of course, in those cases produced by the surgeon to cure a cystitis, or due to cancerous encroachment, or where the cause largely depends on some underlying and pernicious diathesis.

The cause of *these* fistulæ is not local, but is merely a local manifestation of a positive constitutional defect which we should overcome by a proper course of treatment before attempting to close the fistulæ.

In the last two cases I was greatly assisted by using a self-retaining catheter which I have constructed.

The following cases may be illustrative :

CASE I. Mrs. A., age forty-five, had vesico-vaginal fistulæ eleven years. Cause cystitis. Professor B., specialist, made the opening to cure the same; feared to attempt closure; the patient, however, begged him to try, which he did several years later; but it resulted in failure, an inflammation arising, necessitating removal of sutures. The operation was again attempted a year later, with no better result.

The patient came under my care in September, 1888; walls of bladder greatly thickened, capacity of same about one-half ounce.

The following results were then secured at intervals of four weeks :

October, capacity of bladder  $1\frac{1}{2}$  oz.; November, capacity of bladder 3 ozs.; December, capacity of bladder 5 ozs.; January, capacity of bladder 7 ozs.

In February, 1889, I permanently closed the fistulæ; woman remains in excellent health; no recurrence of symptoms; five years have elapsed.

CASE II. Mrs. B., vesico-vaginal fistulæ for fourteen years; cause of fistulæ, Dr. J., specialist, made the opening to cure cystitis.

After fourteen years of indescribable torture, together with unsuccessful attempts to close the fistulæ, the patient came under my care. A more wretched creature than she was is scarcely conceivable. She had also a lacerated cervix, ruptured perineum, walls of vagina and uterus prolapsed, surrounding parts frightfully inflamed from instruments and apparatus worn, and from scalding urine.

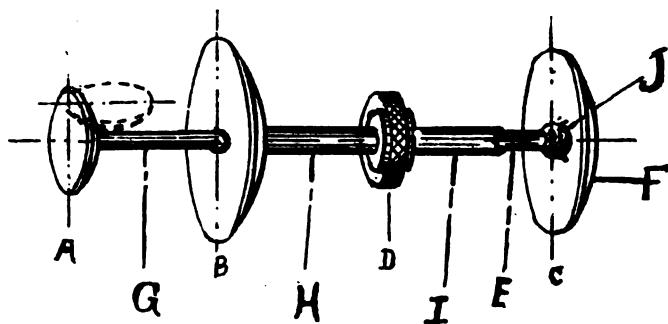
I at once removed all instruments and treated local inflammation.

In November I placed her preparatory under my method; capacity of bladder, about 1 oz.; December, capacity of bladder 2 ozs.; January, capacity of bladder  $4\frac{1}{2}$  ozs.; February, capacity of bladder 6 ozs.; March, capacity of bladder 8 ozs.

Completed all necessary preparatory treatment and preliminary tests in May, 1889, when I operated successfully, patient having had no trouble since.

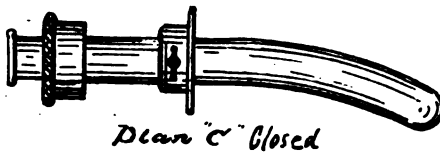
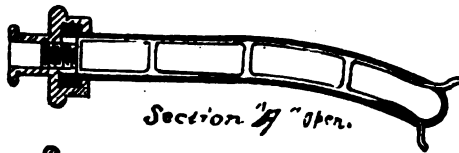
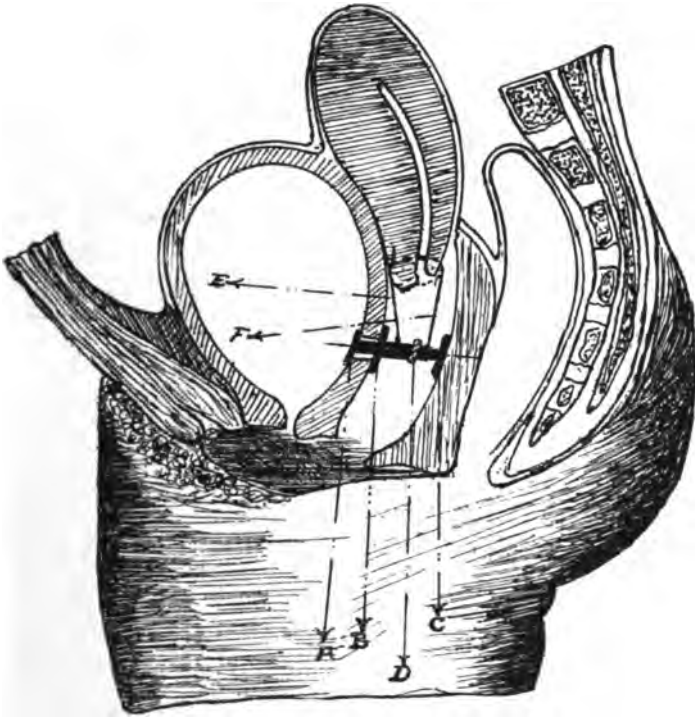
I have also applied the same method in two other cases, each with the same gratifying result. In treating these two cases I received additional benefits from the use of a self-retaining catheter which I constructed.

The instrument herewith presented consists of the following parts:



The letter A shows a concave disk—and this part may also be made oblong—working on a hinge on the rod G. This disk can be turned over at the will of the operator. The rod G passes through the tube H to the nut D, which operates in a reciprocating manner in either direction according to the desire of the operator. The rod G has a thread cut upon it making a perfect screw which, matching the nut D, gives it the reciprocating motion. The disk B is part of the tube H, and is, therefore, supposed to remain stationary. The tube I is the same size as the tube H and is attached to the nut D by a collar. The rod E is the same size as the rod G and is inserted in the tube I so as to make a tight fit, but can be easily moved in either direction. At the end of this rod is the disk C, which is attached to the rod E by a ball and socket joint J, which give the operator an arrangement by which he can move this disk to any angle.

The operation of this instrument is readily seen after following the description herein. The idea being to have an instrument which is small and light, and have the necessary working parts, it is so arranged as to be easily operated, to be made at a small cost and of interchangeable parts.





## DOUBLE VAGINAS.

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BYA. LENORA WHITE, M. D.,  
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THAT anomalies of the generative organs do exist one has only to peruse the various articles on the subject, vouched for by the signatures of men of undisputed reputation. Yet these histories are not so frequent or similar that another cannot be added to the list.

In considering a malformation of any organ a knowledge of its mode of development is essential.

Minot says, "The first trace of the uro-genital system to appear in the embryo is a single longitudinal cord of cells which is seen in cross-sections. This longitudinal cord of cells early develops a central lumen and moves away from the ectoderm, but remains close to the lining epithelium of the body cavity.

"The cavity formed in this wise is the Wolffian ducts. Very soon, as the body cavity grows wider, the region of the Wolffian ducts forms a protuberance into the cavity. This protuberance runs lengthwise of the body, and as development advances it becomes more and more pronounced. It is called the uro-genital fold, from the fact that the entire excretory and genital apparatus is developed from it."

Skene tells us, "The fallopian tubes, uterus, and vagina are developed from the two primary elements known as Müller's filaments. These filaments, when first visible in the embryo, are solid, and are situated on either side of the vertebral column, a little in front, and on the inner side of the two other primary elements, the Wolffian bodies.

"The changes which take place in Müller's filaments during the evolutions of development are as follows: From solid fibers, slightly enlarged, and club-shaped at their upper ends, cavities are formed, and these become canals. Their lower ends approximate and coalesce from below upward, less than half their length. This change takes place between the ends of the sixth and eighth week of fetal life. At this stage of development Müller's ducts are separated by a septum formed from their coalescent walls, so that the united portion shows a right and left cavity.

"These two cavities are soon converted into one, the septum disappearing from below upward throughout the whole of the united portion of the ducts. The lower single canal thus formed is the rudimentary vagina and uterus, while the two upper ends of Müller's ducts form the fallopian tubes.

"From this time to the fifth month there is an increase of tissue, especially in the upper portion of the canal, which renders the distinction between the vagina and uterus apparent."

At the time of birth the primary development is complete. Nearly all malformations are due to the arrest of development at some stage of embryonic life. Should the first evolution be arrested and each duct should grow to itself the result would be a double vagina. The two lateral halves will be divided by a more or less perfect septum. The cavities thus formed will rarely be of equal dimensions. The septum will be composed of two folds of mucous membrane separated by a little muscular and connective tissue. It will vary in size, distensibility, and attachment.

With a double vagina the uterus is usually double. A single vagina with a double uterus is a more common condition than a double vagina with a single uterus, and any faulty development of the vagina is usually associated with

a faulty development of the uterus. Either represents an arrest in embryonic development.

A double vagina, from a clinical standpoint, is of interest, as it presents a possible obstruction to coitus and delivery. The septum may so interfere with the descending fetal head as to call for surgical interference. It may also cause pain by traction. The advisability of an operation will depend upon the anatomical conditions and the symptoms. The following case of double vagina with a single uterus is interesting, and I will relate it in detail:

Mrs. H., age thirty-seven, had been married about eight years. When her first child was born she was in labor twelve hours. After the expulsion of the head there seemed to be some obstruction to the delivery of the body. The midwife, in attempting to complete delivery, broke the neck of the child. The patient dated her ill health from this period, although she had had dysmenorrhea from the first appearance of her menses. After confinement her menses were irregular, painful, and profuse. The time of their appearance varied from six to eight and ten weeks. She had all the direct as well as reflex symptoms of ovarian disease: headache, pain in her back and sides, inability to walk, leucorrhœa, and constant pelvic tenesmus. Severe pains began with the menstrual flow, lasting through the entire five days, completely exhausting the patient, mentally and physically. These repeated attacks so weakened the woman that she declared she was losing her mind. The pain in the left side was constant and always augmented by exertion. After confinement dyspareunia was added to her ailments.

When the woman first presented herself she was thin, pale, anæmic. Upon examination I found a distensible band running vertically through the vagina and attached throughout its entire length. This attachment began anteriorly at the entrance of the vagina, above and below, and ended on the upper and lower surface of the cervix of

the uterus. There was an extensive follicular erosion of the cervix, which was bilaterally lacerated, and the anterior lip was drawn toward the left by the septum. This septum, I noticed, interfered with the introduction of the speculum. If the speculum was inserted on the left side of the band only a small portion of the cervix could be seen, and reinserting it toward the right would often bring the cervix into full view.

There was tenderness and pain when the septum was stretched, and a feeling of faintness. I removed, by local treatment, all exhibition of disease, and sent the patient to the hospital for operation. I had concluded that if the cervix was repaired and the band extirpated the pain would be relieved. Accordingly Dr. E. G. Tuttle operated. After the patient was etherized the division of the vagina was more apparent. What had seemed to be a triangular band was a perfect septum unequally dividing the vagina. The partition on the right side was larger than that on the left. The septum varied in thickness, being thinnest in the middle, and gradually increasing toward the attachments. In the median line of the band it was a quarter of an inch, while at the top and bottom it was fully as thick again.

Large clamps were used, and the band incised through the middle. Both sides were carefully quilted and bag-stitched with catgut sutures, yet when the clamps were taken off the surface bled freely, and it was thought best to remove some of the tissue. The clamps were returned and an inch more of the band removed on both sides. The denuded surface was again quilted and stitched, and the cervix repaired with wire sutures. The vagina was packed with gauze, which was renewed every day after a thorough irrigation. Aside from a slight sloughing around the catgut, there was nothing worthy of note in the recovery. On the tenth day the sutures were

removed from the cervix and the union found to be perfect.

The patient says that she has not had a pain since the operation. Her menses are now regular and painless, and she has no discomfort during the interval. The pains which she had previous to parturition were different to those experienced after the birth of her child. Formerly the pain appeared simultaneously with the menses, but from the time of her confinement there was not a moment when she was free from pain.

Did the operation relieve all this, or was it aided by a psychic influence? The question here arises as to whether the septum formed any support to the uterus, and would an operation materially lessen such support. Again, how did the uterus pass through the evolution of pregnancy with attachments that produced such constant pain, and yet not cause abortion?

It would be interesting to know just what position and complications were at birth. Neither the husband nor the wife was conscious of any deformity, nor did the doctor who was called in to assist the midwife discover any peculiarity. Some author has questioned the existence of a double vagina unless the external genitals are also double.

These cases present a variety of forms, each demanding different surgical measures. I have therefore presented this case to you solely for its clinical value.

# REPORT OF SEVEN CASES OF ANTERIOR VENTRAL FIXATION OF THE UTERUS.

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BY

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THERE are various methods of treating retroplaced uteri with and without operation. Usually these cases are treated by a properly adjusted pessary, etc., which may give temporary or permanent relief, but there are cases where the pessary does no good and causes pain; and where there is inflammation of the pelvic structures, or adhesions, its use is dangerous. Where the uterus is not held down by adhesions, and the tubes and ovaries are healthy, there are very few cases where a laparotomy for ventral fixation of the uterus would be justifiable. But we cannot always positively decide that there is no disease of the ovaries or tubes, and that the uterus is free from adhesions. In laparotomy work adhesions are often found that could not be diagnosed in previous examinations. Where there are no adhesions the Alexander operation has been followed by good results in well-selected cases, where the operation was correctly done and a properly adjusted pessary worn for several months; but this operation was contra-indicated in the cases I wish to report.

CASE I. I operated two weeks ago upon Miss M. of Indiana, aged thirty, who had been an invalid for many years, and had taken three-fourths grain of morphine hypodermatically, frequently repeated. Menstruation had been very painful for ten years. Her nutrition was poor and her inhibitory powers nearly destroyed. In a digital and bimanual examination I found the uterus retroflexed and adherent, but could detect no disease of the ovaries or tubes. When the abdomen was opened the uterus was found adherent to

the pouch of Douglas, and the ovaries were so cirrhotic that there was but little healthy tissue. One tube was inflamed, but no pus was found in it. The ovaries were not larger than the end of my little finger. The adhesions were separated and the tubes and ovaries removed. The uterus was then fastened to the anterior wall at the lower point of the incision by two silkworm gut sutures introduced through the entire thickness of the abdominal wall and into the uterine tissue, under the peritoneal layer, including one inch transversely, one suture being introduced on a level with the tubes and the other a half inch higher in the fundus. Before tying the sutures I scarified superficially that part of the uterus that came in contact with the abdominal wall. The woman had no untoward symptoms, took no morphia after three days, suffers no pain, is out of bed, says she is well, and I feel sure will be entirely restored to health. The uterus is firmly adherent to the abdominal wall.

CASE II. Mrs. C. from Indiana was operated upon three years ago ; her uterus is still held in position. She became pregnant some months after the operation, and induced an abortion at the fifth month. She again became pregnant, and the child was delivered at term. She is now well and her uterus adheres to the wall. In this case I operated by introducing silver wires through the walls upon each side of the wound, carrying them through the broad ligaments, including the round ligaments, but not the fallopian tubes.

CASE III. A little over two years ago I operated upon Miss S. of Cincinnati, removing one ovary and tube which were badly diseased and bound down by adhesions. I used silver wire in this case as in Case II., carrying it through the stump on one side and through the broad ligament on the other side, including the round ligament. Her uterus is still in position and she is restored to health. She had been an invalid for several years and unable to attend to her domestic and other duties.

CASE IV. Mrs. J. of Indiana was operated upon eighteen months ago. The uterine and abdominal peritoneum were united by two buried silk sutures. Her uterus is still in position, and she is relieved of the symptoms for which the operation was done.

CASE V. Mrs. P. of central Kentucky was operated upon eight months ago. She was an invalid for many years. Her ovaries were cirrhotic, and were removed. Her uterus was sutured to the abdominal wall by passing a silkworm gut suture through the stumps on each side. I saw her two months ago, and the uterus was still in position. From a very thin, nervous little woman she has grown to be quite fleshy and is restored to health.

CASE VI. Mrs. L. of Louisville was operated upon seven months ago. The uterus was sutured to the abdominal peritoneum with a buried kangaroo tendon. I saw her last week and her uterus is anteflexed and adherent. She was very much improved and says the operation has cured her. The ovaries and tubes were in a healthy condition and were not removed.

CASE VII. Mrs. B. of Southern Kentucky. Ovaries and tubes healthy and were not removed. Uterus was held in front by silkworm gut sutures carried under the peritoneum of the uterus and brought out through the abdominal wall and fastened as in the first case. The sutures were not removed for two weeks. I did not scarify the uterus, and when the sutures were removed I found that the uterus had returned to its abnormal position.

In some of these cases the sutures were removed within seven days, and the uterus is still adherent. Where the buried sutures were used of course they were encysted or absorbed. In no case did I leave the sutures as long as fourteen days except in the last one, which is the only one of the seven cases in which the uterus did not remain adherent. In future I will always scarify the uterus, and I will either use buried silk, kangaroo, or catgut suture.



## ADENITIS—NON-SPECIFIC INFLAMMATION OF LYMPHATIC GLANDS.

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BY

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THE tendency of glands in the neck and elsewhere to take on congestion and inflammation in certain persons, especially children, who either have inherited or acquired the scrofulous or strumous taint, is universally recognized and has been mentioned by nearly all medical writers since the days of Hippocrates. Sometimes this tendency is the only clew we have to the scrofulous diathesis, but in doubtful cases we are compelled sooner or later to recognize the glandular swelling as part of a constitutional dyscrasia whose depraved influences and tendency are as widespread as the bounds of the organism. But there are other cases occurring every now and again in the practice of every physician of large experience in which there is swelling of the lymphatics of an acute or chronic character, with but little tendency to suppuration, and in children who show nowhere else and in no other way any signs of tubercle, scrofula, or struma. They neither have eczema nor catarrh, nor do they have the general appearance of those who are the manifest subjects of hereditary taint. All that can be said of them is that they are subject to glandular swellings. Why in such cases the cervical glands are more apt to be implicated than others has been a matter of much speculation. That they are so is beyond question.

Treves gives the following table of the comparative location of glandular disease: Neck alone, 131; neck and axilla, 12; groin alone, 6; axilla alone, 4; neck and groin, 1; neck, groin, and axilla, 1.

Some authors endeavor to account for this great preponderance of cases involving the neck by the close proximity to the tonsils, which are the largest aggregation of adenoid tissue in the body; and this theory receives much plausibility from the fact that these glands are so frequently enlarged whenever the tonsils are inflamed.

But tonsillitis is not the only proximal inflammation or irritation that may give rise to enlargement of the cervical glands. Eruptions on the skin, face, and scalp, coryza, diseases of the ear, and even dentition may also act as indirect causes. Gastric derangement also should be classed in this category, but beyond doubt "taking cold" is more often than anything else the immediate or exciting cause. That the victims of adenitis are generally delicate, highly organized, and sensitive children is true, but according to the accepted pathology of that disease neither mere delicacy of organism nor mere depression of vital powers would be sufficient to produce the condition known as scrofula. Even adults in ordinary health, and who have never exhibited symptoms that could by any possibility create a suspicion of scrofulous inheritance, may have temporary enlargement of a gland, and that enlargement may go on to inflammation and suppuration.

What is true of adults is especially true of children in whom the glandular structures are proverbially sensitive to peripheral irritation or to reflex influences through the sympathetic nervous system. This will be more readily understood by recalling certain facts from anatomy and physiology relative to the lymphatic glands and their functions. The lymphatics themselves originate in the areolar interspaces and are everywhere present. They do not go far from their point of origin before they meet other lymphatics with which they coalesce and expand into a lymphatic gland with efferent ducts or lymph channels whose purpose is to convey the lymph corpuscles into the general circulation.

Just how these lymph corpuscles originate is not known, but every efferent duct is filled with them, and anything which interferes with their progress toward the general blood stream is productive of mischief.

- In children the waste and repair of tissue are very active, and the functions of the lymphatics is to pick up waste products, which are mostly albuminous, and conveying them first to the lymphatic glands, bring them ultimately to the general circulatory system. All effete material or foreign substance which has found its way into an areolar interspace is taken up by the open mouths of the lymphatics and passed through the glandular mechanism. Now bland and soluble matters, when thus taken up by the lymphatics, pass on without hindrance and without producing congestion or irritation. But it is different when the matters in transit, instead of being bland and soluble, are insoluble or irritating. Then the gland is liable to first irritation and then inflammation.

When the surface of the body is chilled, as from cold, all of the superficial vessels are contracted in consequence, the lymphatic as well as others. The effect of this contraction is to congest the glands by preventing the onward flow of the lymph corpuscles. Hence we see how easily from cold a gland may become engorged, congested, and then inflamed.

In the neck the cervical glands are large as well as numerous, being made up of innumerable small glands conglomerated together. All glandular structures are in the closest relations of sympathy, and so we see how an inflammation of the tonsils, to use these organs again by way of illustration, may extend to the adjacent glands of the neck.

In scrofulous subjects the processes of metabolism are imperfectly performed, the elaborated tissues are only partly elaborated, and the waste products are only partially soluble. Hence such persons have constant trouble from glandular disease. But others, also, are liable to glandular

engorgement from cold or peripheral irritation, although at other times and under other circumstances the lymphatic system is in perfect working order, and the processes of metabolism are carried on in a physiological manner.

In scrofulous subjects glandular swellings are general in their causation, while in non-strumous subjects these causes are mostly or entirely local. Clinical experience teaches that when inflammation is set up in a gland the changes effected therein are manifested first in the deeper portions of the glandular structure, beginning in the medulla and extending thence to the cortical portions and never invading its capsule. Sometimes, when the gland is merely congested or engorged, and not inflamed, the obstructing material only undergoes partial absorption and remains a fibroid callus. A gland is then said to be indurated, and may remain in this condition indefinitely.

In other cases the gland becomes inflamed and pus is formed, which finds a superficial outlet or burrows into the deep-seated structure before discharging into some internal organ or tissue.

We have entered into this somewhat elaborate argument to prove that all glandular swellings are not necessarily scrofulous in their nature; that certain glands, especially those in the neck, may be temporarily engorged, and this engorgement may go on to inflammation and suppuration, either of the gland itself or of the tissues around it, without implying any perversity of constitution or any morbidity of histological processes or products other than those of a local and generally ephemeral character.

*Symptoms.*—There is one point of difference between glandular infiltration of strumous origin and that non-specific form which we are now considering. The latter is always acute and accompanied with acute symptoms, while scrofulous glands are proverbial for the chronic and indolent character of their ailments. The more marked the strumous diathesis the more true is this observation.

A scrofulous gland may show no symptoms of its distress in pain, or heat, or other signs of inflammation. A lump or tumor of considerable size is often the first intimation of glandular disturbance. This insidious history is not characteristic of acute non-specific adenitis. In this variety of glandular inflammation no sooner does the gland begin to swell than it becomes tender and sensitive to the touch.

In many cases there is some febrile disturbance, and there may be headache and vomiting. The gland itself does not usually become red and inflamed on the surface until some days or some weeks have passed. Besides being tender and sensitive to pressure it gives rise to but little inconvenience. It is very subject to exacerbations, one day being larger and more tender, and the next day perhaps behaving as if resolution were progressing rapidly. The formation of pus, if it takes place at all, does so very slowly, and may threaten many times before all hope need be abandoned of its prevention.

Sometimes a single gland, or a whole string of glands, may be affected at once, or a number of neighboring glands may be simultaneously involved, and the whole number be matted together in a common swelling. When inflammation succeeds to engorgement it is always of low grade, and the formation of pus is not accompanied by any of those symptoms which ordinarily attend suppuration.

It is for this reason that the older writers referred to a suppuratory gland as a "cold abscess." After an indolent and chronic career of weeks, or sometimes months, the affected glands either slowly undergo resolution and disappear or become acutely inflamed and suppurate. In some cases the adenitis may be of only short duration, lasting but a few days, but the tendency is as stated above, and the average duration is weeks rather than days.

The tendency to adenoid inflammation is sometimes met with in adults, usually males, and may therefore be of life-

long duration ; but, as a rule, it rarely persists after puberty. When occurring in delicate children in early life it is reasonably safe to expect that with better health and the progress of adolescence the glands will be less sensitive and less liable to acute inflammation.

*Treatment.*—While the affection here described is manifestly not due to scrofulous or other constitutional taint in the blood, it is usually, if not always, associated with more or less general derangement of the system. It occurs most frequently in children whose digestive organs are easily disturbed, and who, from too rigid confinement indoors or from constitutional delicacy, are very subject to cold.

Glandular inflammation, too, is frequently commingled with some other disease, as scarlet fever, measles, diphtheria, or other affection of the throat. In such cases it is to be regarded as a complication, and treated as such.

When occurring idiopathically, or in connection with an ordinary cold, the treatment should be more hygienic than medicinal. Cool sponge baths, frequently repeated, are very useful. These children do not bear confinement indoors, either in school or in "apartments," which are now so fashionable. They should be out of doors as much as possible, and be fed on coarse but wholesome food. If there is such a thing as "hardening" delicate children by exposure to the vicissitudes of weather, it should be judiciously tried in cases of this kind. Coddling only makes matters worse. Exercise, either active or passive, a due regard for diet, and plenty of fresh air are alone sufficient, in many cases, to overcome the tendency to glandular stenosis and consequent inflammation.

When the glands do become swollen and inflamed they should be rubbed with some warm unguent, like vaseline or camphorated oil. Even gentle friction with the hand, continued for some minutes and frequently repeated, will be found serviceable.

There need be felt no fear of "scattering" the disease.

Such a thing is impossible. There is no more danger of such a result than there is of scattering a mastitis, for the two affections are very similar in causation and course. Indeed the medicinal treatment is very similar. In cases of chronic character, with little or no febrile accompaniment, hepar sulphur, given three or four times a day, will often bring about resolution in a very short time.

As the subjects of adenitis are usually small eaters and of low vitality, we are in the habit of giving them, by way of a tonic, and in the absence of more clearly indicated homeopathic remedies, chin. arseniate 3x, a 2-grain powder three times daily half an hour before eating. This remedy is a splendid appetizer and increases the *vis medicatrix naturæ*. Another remedy which is rarely used in glandular troubles, but which has shown decided action in two cases in which we have given it for other indications, is aurum met. In two recent cases of adenitis whose symptoms otherwise called for aurum we noted a rapid subsidence of the glandular swelling, although our prescription was given with reference, in one case, to "seeing mice" every night about midnight, with all sorts of fanciful dreams, which were so real that the child was afraid to go to bed. In another case in which we prescribed this remedy the child (five years old) would not be left alone at night, or even in the daytime, but begged his mother to stay with him. He would awaken after a short sleep at night, and refuse to be comforted unless someone slept with him. Fear or fright, and dread of being left alone, are strong indications for aurum. Other remedies of value are mercurius, apocynum, phytolacca, thuya, and sulphur. The glands themselves should never be poulticed or swaddled, nor opened with a lance, until there are unmistakable signs of pus within or about the glandular structure.

INFANTILE PNEUMONIA SIMULATING MENINGITIS, WITH SOME DIAGNOSTIC PHENOMENA.

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BY

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IN presenting this brief synopsis it was deemed non-essential to detail or separate the different varieties of pneumonia or meningitis. No doubt every practitioner has experienced difficulty in securing any subjective symptoms in children, especially if under the sixth or seventh year. The diagnosis, therefore, depends almost entirely upon objective manifestations, and even these are oftentimes hidden under the effects of so-called soothing syrups and other *quieting* nostrums. We may, it is true, in some few cases, get a history of chilliness, drowsiness, loss of appetite, cough, and evidences of thoracic soreness, occasionally vomiting and convulsions; but when the onset of the disease is rapid these are generally absent. Owing to the severity of the weather in the East during the past two years, and its extreme variations, infantile pneumonia has been exceedingly prevalent, but has responded very kindly to treatment. The most prominent symptoms observed have been as follows: High temperature; accelerated pulse, and respiration; desire to lie upon the back, with arms over the head or extended upward, thus allowing for the utilization of all the space in the chest; and dyspnœa. Upon exposing the body there is noticed a marked hesitancy in expansion on the affected side, and abdominal respiration is decidedly marked. All of these symptoms being plainly demonstrated to the observing eye, auscultation and percussion will, if the lung changes are far enough advanced, determine a diagnosis of pneumonia.



Meningitis may, and sometimes does, present nearly all of the above phenomena; but in addition thereto will be observed rolling or boring the head into the pillow; picking at the nose or ears; strabismus, convergent or divergent; shrill, piercing shrieks or moaning; twitching of the facial muscles or general subultus; tonic or clonic drawing up of the limbs; retention of urine or profuse urination, sometimes of an ammoniacal odor, and high-colored diarrhea; dilated or irregular pupils, and a marked desire to be left entirely alone and undisturbed. It has been of material aid in making a diagnosis of meningitis, especially when of the tubercular form, to learn the previous history of the parents' relation to consumption, or any of the diseases regarded as having an hereditary tendency. As the totality of the symptoms, and not the name of the disease, governs the selection of the remedy, we can therefore be noncommittal as to an exact diagnosis, and still be accomplishing much that is beneficial. Herein lies one of the many advantages possessed by practitioners of homeopathy over the so-called regular school, or, to be more correct, irregular. The remedies most frequently indicated have been bryonia, asclepias tuberosa, chelidonium, lycopodium, tartar emetic, hepar sulphur, phosphorus, iodine, ferrum phos., and ipecac. The indications are too well known to be presented here.

I cannot too strongly emphasize the necessity of securing the utmost confidence of children while in health, and denouncing the practice some parents have in trying to secure obedience by threatening to call the doctor and have him do some terrible thing to them if they do not obey. A few minutes spent in getting on the right side of "the best and prettiest baby ever born" while enjoying good health will bring its just reward when called to him in sickness, allowing of a more successful examination, and consequently a much better understanding of the case and superior results.

## PHTHISIS PULMONALIS AS A SEQUEL OF MEASLES.

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BY

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SEQUELÆ to measles are not so frequent as to scarlet fever. It is rather exceptional for a case of scarlet fever to recover without some sequel, but with measles the exception is to have sequelæ.

Raue says (in "Special Pathology and Therapeutics") that "under homeopathic treatment sequelæ are of very rare occurrence." He also mentions as a most prominent sequela "chronic catarrhal cough and chronic pneumonia, which may end in consumption." Duncan ("Diseases of Children") says: "Another sequel to measles is tuberculosis. Sometimes it develops very rapidly and intensely as miliary tuberculosis, so that patients never recover enough to leave bed, but continue to suffer from fever and to cough and emaciate from the time the exanthem disappeared. Generally, however, an interval is observed between the disappearance of the eruption and the first appearance of the tuberculous symptoms. These children get up again and are free from fever, having good appetite, and the measles are forgotten. A slight bronchitis, however, remains, and persists in defiance of the best nursing and uniform temperature, etc. Very gradually aggravations are noticed toward evening, followed by general indisposition, loss of spirits and strength, and with this the cough increases in severity. The emaciation becomes more and more marked, tuberculous phenomena are soon physically demonstrable, and in most instances rapidly advance to a fatal termination. Should this be arrested the

child will for years be prone to bronchitis and experience new tuberculous attacks."

Hartman ("Diseases of Children") mentions phthisis as one of the sequelæ of measles. Reynolds ("System of Medicine") says: "Acute tuberculosis or chronic phthisis may occur during the course of the disease, but usually first gives evidence of its existence after the fever has declined. Acute tuberculosis follows measles more frequently than any other of the acute specific diseases, whooping cough being perhaps excepted." Pepper ("System of Medicine") says: "Chronic pulmonary tuberculosis is one of the most formidable and frequent sequelæ of measles. It is not an uncommon occurrence that with the exception of some trivial bronchitis a patient may apparently recover his health completely, and only after a lapse of time slight daily elevations of temperature, accompanied by loss of appetite and emaciation, first give warning of the impending danger. Granular meningitis, or general miliary tuberculosis also frequently follows in the wake of measles, connected in many cases with foci of caseous degenerations in the involved lymphatic glands or unabsorbed pneumonic exudation."

Ziemssen's "Cyclopedia of the Practice of Medicine" says: "It is not uncommon for children apparently recovered from measles or convalescent to be seized anew with difficult respiration, and after a longer or shorter duration of the new disturbance to even die, sometimes of cheesy pneumonia, with or without tubercles, sometimes from general miliary tuberculosis or tubercular meningitis, the causes of which, as it appears, must be specially sought in the cheesy degeneration of the swellings of the lymphatic glands occurring in the course of measles. The tuberculous bronchial glands in particular afford a frequent point of origin for tuberculosis of the lungs after measles."

Hennoch ("Lectures on Diseases of Children") says: "Chronic broncho-pneumonia is undoubtedly the most fre-

quent sequel. In a series of cases it terminates fatally after a number of months, under increasing emaciation and hectic, and we even find on autopsy either chronic broncho-pneumonia with dilatation of the bronchi and small pulmonary abscesses, which have been formed by the destruction of the alveolar walls and coalescence of the pulmonary vesicles, which were filled with pus, or more frequently cheesy degeneration of the lungs and bronchial glands. The opinion that measles has a special tendency to the production of tuberculosis depends, as I believe, upon the fact that this disease, like whooping cough, on account of its frequent complication with broncho-pneumonia, especially in predisposed individuals, may give rise to cheesy processes in the lungs, followed by miliary tuberculosis."

Notwithstanding the fact that "acute tuberculosis follows measles more frequently than any other of the acute specific diseases," and "is one of the most frequent and formidable sequelæ of measles," I have never observed, or should possibly say, to speak more correctly, I have never recognized, a case of this kind until this year, though I have treated hundreds of cases of measles. Could the explanation of this be, as Raue says, that "under homeopathic treatment sequelæ are of very rare occurrence"?

This summer I have had under my care five cases, with a possible sixth, of phthisis pulmonalis, or of chronic pneumonia, following measles, and which it is the object of this paper to report. My first case was that of an ill-nourished child of about three years. It suffered from chronic intestinal catarrh, due to improper feeding. All of its surroundings were unhygienic. It was taken sick with measles the latter part of April. The eruption developed very tardily, but eventually very well, so that by May 6 I ceased visiting the case, as it was convalescent and to all appearances required no further medical treatment. May 15 I was recalled, and found the child not as well as when I dismissed her. There was very persistent rough cough,

hectic flush, progressive emaciation, diarrhea, capricious appetite, and excessive thirst. My treatment produced no impression on the case. It progressed steadily to death, which occurred June 13, about six weeks from the onset of the attack of measles. I gave in this case arsenicum, arsenicum iodide, psorinum, calcaria phosphorica, and argentum nitricum, as they seemed to be indicated, the latter on account of the great craving for sugar and candy. I had her also take all the bovine she would.

The next case was a boy about five years, whom I saw first the latter part of May. He had been under old-school treatment for some six weeks. His illness started with an attack of measles, from which he appeared to recover, but in a short time was sick again with fever, etc. They recalled their doctor, who, after a short time, pronounced the child again well. But as he got worse again they concluded to change the treatment and I was called to the case May 21. The little fellow was very pale, waxy, and emaciated; had a hard, rough cough, without expectoration; rapid respiration; no dullness on percussion; bronchial breathing and coarse râles heard on auscultation; temperature  $104^{\circ}$ ; diarrhea; complained much of pain in the stomach, which was aggravated by drinking cold water; was thirsty, restless, worse at night and every other day. Prescribed arsenicum 3x. The following day, May 22, the temperature was  $100^{\circ}$ , a fall of four degrees, and in every way the child was better. The arsenicum was continued.

May 23 the temperature was up to  $104^{\circ}$ .

May 24 the temperature was up to  $104^{\circ}$ .

May 25 the temperature was up to  $99^{\circ}$ .

May 26 the temperature was up to  $99^{\circ}$ .

The arsenicum 3d was given all the time and the child was improved in every way, and as I wanted to leave next morning for Chicago I dismissed the case. When I returned home in two weeks I found the child as sick as he

had been before. Under treatment he improved again, only to again relapse. I now warned the parents of a strong probability of a fatal termination, and for my candor was dismissed from the case. I was able, however, to keep informed as to its progress. My successor was an allopathist, who, after a time, was succeeded by another allopathist, and he, in turn, by a homeopathist, upon whom devolved the duty of furnishing the death certificate. The child was sick over two months, steadily going down, but enjoying brief periods of improvement, which as the disease progressed became fewer and of shorter duration.

About the same time that I was called to the last case I took charge of a case of whooping cough that was just getting over an attack of measles. This child, and another one that had been similarly affected and died, was under the care of a physician who graduated at a homeopathic college in Cleveland a few years ago, but who now, according to Polk's "Medical and Surgical Register of the United States," disclaims being a homeopathist, and styles himself a regular. He had informed the parents of the child that it was useless to give medicine for whooping cough. His services were dispensed with. Under the influence of the indicated remedies, which were principally arsenicum, cina, and kali sulph., the child got over the whooping cough, and also from a bad diarrhea, but did not get well; on the contrary, it continued to cough, with coarse, bubbling râles, heard all over the chest, evening fever, progressive emaciation and exhaustion. In this condition the child passed from my care and shortly after died.

In the early part of June, while I was absent from the city, the two daughters of D. E., aged about five and eight years, took down with measles and came under the care of Dr. B., who attended them until my return home, when I was called. I found each taking three remedies in rotation. They were over the measles, but had an irregular fever, prostration, diarrhea, and cough. Under what I considered

the indicated remedy in each case they improved, and when apparently well would relapse, the temperature run up, cough increase, diarrhea set in, etc. In all these cases a most constant and peculiar symptom was picking, either picking the nose, lips, or fingers. Cina or arum triph. were confidently prescribed on the strength of this, but without avail. In the last case change of climate was also tried, but it was without beneficial result.

My last case is to me most interesting, as it differs from the others in this: that the child has to all appearances made a perfect recovery, though from the unfortunate experience I had had I made a very unfavorable prognosis to the parents. For my candor I was not in this case dismissed, but rather the more strongly adhered to.

The patient was a child twenty-two months old, who had never been sick except with the whooping cough, from which she was suffering at the time of the attack of measles, though the whooping cough had not affected the general health in the least. The measles set in on July 24 with very high fever and most persistent sneezing; the cough also became much more troublesome. Under belladonna the measles ran their course in the usual length of time. The eruption had been so dense that desquamation followed. The cough remained very severe, and the child instead of feeling and resting better was restless and sleepless, and hot, especially at night, the temperature keeping up after the disappearance of the eruption to from  $102^{\circ}$  to  $104^{\circ}$ , sometimes higher in the morning, and sometimes higher in the evening, the latter being most frequent. Dyspnoea was very marked, so much so that the baby could scarcely nurse "for want of breath." The bowels were loose, the discharges being very offensive. The upper half of the right lung was consolidated, the consolidation progressing from the apex downward. This condition persisted for two weeks after the subsidence of the measles, when Dr. J. B. McClelland, in consultation, prescribed one dose of

sulphur 200, to be given on the morning of the day following the consultation, no medicine to be given the night before or the day after. This was done. The temperature at the time the one dose of sulphur 200 was given was 103°. The next morning it was 101°. Improvement in every way was steady, so that in one week from the giving of the sulphur the temperature was normal, and had been so for two days, the lung was clear, and in a few days I dismissed the case well except for the pertussis. For a week I heard nothing from the child; then it was brought to the office, sick again. They thought it had taken cold. The cough was worse, with yellow expectoration, yellow nasal discharge, fever without thirst, the upper part of the right lung again consolidated. Temperature 102°. The child wanted to be out of doors all the time. I prescribed *pulsatilla* 3d, a dose every two hours; also a teaspoonful of pure cod-liver oil three times a day. Under this treatment the child improved rapidly, and in a week the temperature was normal and remained so, appetite restored, cough much less, but there was yet dullness on percussion over the upper part of the right lung. One dose of sulphur 200 was given as on the former occasion. After waiting for three days and no improvement being manifested, I gave one dose of sulphur 30, which was followed by improvement, the lung slowly but steadily clearing up, from below upward. The child was then taken to the country, and I am informed that its health is now perfect.

I have come to look upon cases of measles where the temperature keeps up after the subsidence of the rash, or where the temperature rises after having dropped to or about normal as to the utmost seriousness. They may have no cough whatever, or a very slight one, but are apt to get into a general phthisical or wasting condition characterized by two constant features, namely, irregularly elevated temperature and progressive emaciation. With these there may be a variety of other symptoms. The



illness is usually very protracted, and the termination almost invariably fatal.

When in attendance at the World's Congress of Homeopathic Physicians in Chicago last June I was requested by Dr. Webster and his wife of Dayton, O., to go with them to Englewood to see their sick grandchild. This was a case of what had been a healthy and beautiful little girl of seven years. She had measles in April, and has been sick ever since with what at various times was considered pneumonic fever, gastric fever, typhoid fever, etc. When I saw her she was enjoying one of her periods of amelioration and fall of temperature, but emaciation and exhaustion were very marked. In reply to a letter of inquiry Dr. Webster writes me, under date of September 13, 1893: "Our little granddaughter still lives, but has had a hard time of it. The prospects are that she will recover, although for many weeks they despaired of her life. She is a skeleton." This child has been sick now for over six months, and while I sincerely hope that their fond expectations may be realized, I am of the opinion that this is a case of phthisis of the kind I have described, and that recovery is not to be expected.

I can suggest nothing in the way of explaining why some cases of measles terminate in this manner. It is not due to any constitutional taint, as children of the most healthy parents may go this way; and, on the contrary, I have seen children of scrofulous, consumptive, and syphilitic parents pass through measles of severe type, and recover without a sequel of any kind. Neither can I suggest anything in the way of treatment to prevent patients with measles from going into this condition, except again to repeat the words of the venerable and honored Raue: "It is but just to remark that under homeopathic treatment sequelæ are of very rare occurrence."

*Discussion.*—Dr. C. S. Middleton: Dr. Martin has so thoroughly discussed the subject that there is very little

to add, but I wish to give warning that in all cases of measles followed by high temperature I never let the case go out of my hands. I am particularly careful to caution my patients that, though measles may be a simple disease, it is sometimes fraught with much danger. I never lost but one case of measles, and that died from some meningeal complication.

Dr. E. R. Snader: I wish to say a word in regard to Dr. Martin's paper. He speaks very dubiously of the prognosis in cases of sequelæ following measles. While he is unquestionably right, I think the picture is too dark, for this reason: Clinically, you can very frequently trace back a case of phthisis to an attack of measles suffered years before. Therefore cases which have had measles get well apparently, pass through a period of latency, and finally break down. So I think it behooves us to give a guarded prognosis, and work vigorously to secure this period of latency. I have been able, through my dispensary work, to trace phthisis back to childhood, starting in an attack of measles. This time of latency may cover a period of comparative health, the individual not believing that there is anything wrong with him; but under stress of certain conditions the process again develops.

Dr. Cooper: Allow me to ask if any microscopical examination of the sputa was made in Dr. Martin's case?

Dr. Martin: No, sir.

Dr. Cooper: It is difficult to decide the true pathological character of cases of that kind without close investigation. Affections of the respiratory tract after measles may become grave and death occur, even where there is no tuberculosis; but where the latter is constitutional or hereditary it would, in such cases, be almost impossible to secure a softening of the tubercular masses after they are once formed and deposited.

Dr. E. R. Snader: In regard to the position just taken by Dr. Cooper, I wish to recall that Dr. Martin said

"phthisis pulmonalis." Now some of these cases may be tubercular, others may be only a broncho-pneumonia, and yet present about the same picture as tuberculosis. It is, therefore, really not essential, in treating of this matter clinically, to define these cases as tubercular in origin. They pursue a course identical with that of tuberculosis.

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## THE PREVENTION OF DIPHTHERIA.

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BY

WM. A. SEIBERT, M. D.

EASTON, PA.

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HOMEOPATHY, Listerism, and bacteriology have each performed invaluable indirect services to humanity that present a similarity, though they themselves bear no further resemblance. Homeopathy thoroughly revolutionized the so-called "regular" medical abuses into much milder therapeutics at least, besides in itself being the most important therapeutic discovery of the age. Listerism did a similar service for surgery by tabooing uncleanly and careless work, even if it, *per se*, possesses no merit. Bacteriology has made its similar impression on preventive medicine by encouraging stricter methods in general hygiene, and enforcing isolation of the infected, though itself probably overrated.

It will be noted that the measures that had been adopted as most efficient in the prevention of diphtheria before the field of bacteriology was open turn out to be also eminently uncongenial to the existence and multiplication of the diphtheria bacilli. In the discovery and description of the various bacilli and their ptomaines Klebs and Loeffler simply reduced to scientific study what had been empirical in the prevention of diphtheria. They may not be the

sole cause of the disease; they may be simply unhygienic accompaniments, but they seem uniformly present, and the elimination of so constant a factor becomes an extremely desirable object. Their discovery has probably not enhanced our knowledge of the medical treatment of diphtheria, but it has most emphatically drawn attention to its preventive treatment.

Usually many things can be done by physicians, health boards, and communities to lessen the probabilities of persons contracting the dread disease. It is possible in the scope of such a paper only briefly to call attention to a few dominant facts that are to be pre-eminently considered in the prevention of diphtheria.

Before the disease appears, after it does make its appearance, after convalescence or death—all the time—nothing goes so far toward prevention as good pure air and sunlight and plenty of both, at the same time being mindful that draughts are deadly. Bedrooms should contain fewer occupants to the cubic feet of contents, and they should be more thoroughly ventilated night and day, winter and summer. Everything that might vitiate the air in the least should be banished from the room, especially that article so frequently allowed to be even without cover under beds. There should be fewer curtains and hangings to interfere with abundant rays of sunlight and free circulation of air, besides furnishing inviting lodgings for impurities, including germs. The air will also eddy and form stagnant pools back of the hangings, in which impure air may become more impure, because of the retention of organic and decaying odors that will unavoidably find their way upward, particularly from the kitchen. Sewer air—or sewer gas, as it is often improperly called—is another source of contamination of air, and, being such an extraordinary vehicle for and breeder of poisonous germs, it must be rigorously excluded from our houses. It is also hardly open to question that the continual breathing of air

polluted by emanations from sewers often produces more or less serious derangements of health predisposing to any disease. Soil air is still another cause of vitiating the air we breathe, and has probably had a most active interest in the epidemic that has been visited upon Easton during the past two years. For several years there has been one incessant turning up of our old streets, many of which have been almost hermetically sealed by overlying macadam. At first it was necessitated by the establishment of a system of sewerage over the greater part of town requiring digging to great depths in such a hilly region; then followed equally, if not still more, extensive throwing up and piling up of ground all over the town for the purpose of establishing an elaborate system of electric railroading; and then followed, and is still being continued, another digging up of the streets and hauling through the town of sufficient surface to permit of modern street paving. We are unable to assert with confidence that this alone has been the cause of our epidemic; for we are having other notable sources of air contamination at Easton, and it may be that we have simply suffered the effects of the diphtheria wave that is supposed to repeat itself every six or seven years. Nevertheless soil air is contaminated air, and this undoubtedly does make the certainty of the contagion greater. Everything impure in the cellars, yards, and neighborhoods that might render our air impure should be removed, remembering that one decaying rat or one pail of swill refuse pollutes more air than a massive and unsightly pile of coal ashes. Privies and cesspools need especial attention, for they must render impure many cubic feet of air daily, much of which will get into our houses.

Pure atmospheric air and sunlight are probably nature's disinfectants, and are the best now known for universal use; and as long as there is no epidemic they will probably answer every purpose in the prevention of diphtheria. In time of epidemic the free use of the best deodorant and

best artificial disinfectants known are not gainsaid, but we do, incidentally, disapprove of strong-smelling chemicals that are supposed to disinfect. But pure air, sunlight, and all the best disinfectants known avail nothing if the food or drink be infected, or if we be otherwise exposed to the contagion. Water—that can be very easily contaminated by the soil, air—and milk form two very potent vehicles for carrying the bacilli. Direct contagion often results in school and from books, especially where the free school-book system exists, and from infected chickens, cats, canary birds, and other pets. After the bacillus makes its presence in a home known, then the one predominant feature in the preventive treatment of the disease is isolation—prompt, complete, and continuous isolation of all infected persons and things. All but the sick and those waiting upon them should at once be removed from the house, and we do believe thorough quarantine should be productive of the best results. This, however, is not feasible unless established by law and carried out by paid officers. The anxiety to prevent at this stage becomes so intense that everybody is apt to become quite uncharitable and even cruelly severe in trying to enforce quarantine, a thing impracticable, though possible, in cities. Health boards will do things that keep a community in a constant state of terror. They will publish in the dailies a report of the new cases, and display a flag, or, as at Easton, a large, blue card with the word “diphtheria” in large letters upon it at the most conspicuous place on the front of the house. Almost every child, and very many adults, develop a “holy horror” of the disease. Fear may have something to do with susceptibility, but it has an undoubted influence upon the prognosis in victims of the scourge. The question arises whether newspaper reports in detail could be omitted, and whether it would not be possible to serve an equally sufficient warning to those about to enter the infected house. And the physician himself will do what seems sufficient to alter the

prognosis in many a case. Take, for example, the recommendation in Burnett's recent elaborate treatise upon "Disease of the Eye, Nose, and Throat": "If diphtheria be suspected the physician should, before entering the sick room, remove his coat and vest and cover his body, neck, and extremities with a sheet fastened around the neck." Theory and practice may be handmaids, but they are certainly at times quite uncongenial. May the purpose of this sentiment not be misconstrued, for the good of the community should be uppermost, and its safety is not bartered if these prophylactic measures be reasonably modified. It is not the object of this paper to excuse careless physicians. They should not expose themselves unnecessarily, their visits should be brief, and on leaving the house it were best to wash face, head, beard, and hands in an antiseptic lotion, such as one of corrosive sublimate.

After death or recovery the predominant fact for consideration, in order to prevent the spread of diphtheria, is thorough disinfection and fumigation. These methods include scraping of the walls, repapering and repainting them, and free ventilation all the time. Most careful attention should be given to the disinfection of the patient himself before readmitting to school, since many cases originate from exposure in public schools. School boards and superintendents, as well as health boards, are the servants of the people, and should act always for the best interests of the people. It is not sufficient, on the contrary, an absurdity, to expect physicians to give certificates guaranteeing safety in readmitting school children. Physicians cannot, in the light of present knowledge, conscientiously give a certificate such as school authorities generally exact without the expenditure of much time and possibly repeated bacteriological examinations. School authorities find it very convenient to shift duties upon others, when they should be expected to co-operate with the health board, and should require of the physician in this matter only a certificate

that their laws have been complied with. Stamping out a diphtheria epidemic is a matter of the gravest import, and needs general premeditated co-operation.

In accordance with the latest and most exact experiments the following disinfecting agents have been preferred as the best of all the hundreds recommended by the many authorities consulted: Boiling water or live steam ( $100^{\circ}$  C.) for half an hour is the very best for all kinds of material not destroyed by moisture. Dry heat ( $130^{\circ}$  C., equal  $266^{\circ}$  F.) for two hours for articles which would be injured by moisture. Chloride of lime very freely used for all discharges, including vomited matters and sputa. This should contain at least twenty-five cent. of available chlorine, and should be dissolved six ounces in a gallon of water. Bichloride of mercury, 1-500, after adding five grains sodium chloride for every grain corrosive sublimate, for washing surfaces and for soiled linen, etc. This should be weakened to 1-2000 or 3000 for repeated application to the surface of the body. Milk of lime made from freshly burned lime by mixing the hydrate with water in the proportion of 1 part to 8 by weight. This is the best agent for disinfecting privies by adding 5 parts of it to every 100 parts of daily increment. This is also very valuable as an application to walls of plaster and wood. The dry fresh quicklime is also one of the best absorbents of moisture from the atmosphere known, so that pieces of it placed about the house and cellars to air-slake will not only dry the air but will destroy poisons contained in the moisture where they generally do exist. Platt's chlorides, bromo-chloralum, and the like are the best kind of deodorants, but they have been proved disinfectants of no worth, and should not take the place of the better disinfectants. Finally, sulphur for "fumigation." We should remember that the anhydrous sulphur dioxide has very little germicidal power, and that therefore it is, necessary to moisten the objects and surfaces, or to intro-



duce steam into the closed apartment with the sulphur fumes, so that the very valuable disinfecting agent sulphurous acid is formed. Three pounds should be used in each one thousand cubic feet.

Such, then, are the leading measures I should recommend as most likely to prevent the propagation of diphtheria. Recapitulating the predominant facts:

1. In non-epidemic periods plenty of pure air and sunlight in houses, and bedrooms in particular.
2. In epidemics plenty of pure air and sunlight, re-enforced by well-selected disinfectants.
3. At all periods avoiding exposure to infected persons and things.
4. When the disease makes its appearance in a house, then isolation, superadded to the continuous and vigilant disinfection of the patient and his surroundings.
5. After death or recovery, fumigation and thorough disinfection and house cleaning.

All through this process to prevent diphtheria is observed the crusade against the bacillus: on the one hand, the pure air and sunlight to prevent his existence; and on the other hand, disinfection and fumigation to kill him. It is easy, however, to be engrossed with these absorbing and important phases of prophylaxis to such an extent that we mistake the cause or accompaniment of the disease for the disease itself, and thus forget the personal element with its predisposition and the value of prophylactic medicine. The homeopathic remedy most frequently indicated in the cases then extant, or *apis mellifica* in particular, administered in time of epidemic, should be added to the above means of prophylaxis, and epidemics of diphtheria would become appreciably diminished in frequency and severity.

## NEUROSES OF CHILDHOOD.

BY

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THE study of sanitary science and prophylactic treatment to secure for the child perfect development and good health is becoming popular. But he who runs may read that disease is marked upon the faces of the great portion of the multitude; consequently every practitioner is busier curing the ills that exist than in teaching preventive methods. We are told by a recent writer that "heredity accounts for the sameness of our race; the differences are the work of environment."

We no longer inherit disease, but are born with a tendency to this or that malady, and our surroundings may produce an exciting cause for its development. Of the morbid conditions demanding relief none are more important than the neuroses of childhood. These disturbances are numerous and varied, some arising from constitutional dyscrasias, others being induced by the climate, lack of care, temper of the attendant, or some unfavorable surrounding. Though we may not be able to suggest a cure-all for every case, it may be profitable to occasionally review the facts as we meet them.

Sometimes we recognize an irritation which is nerve-wearing and gradually reduces the vitality, and again it is a form of well-marked disease. Among the latter claiming our attention is coryza of infants. An able authority says: "This flow, more or less profuse, from the mucous membrane of the nasal cavity, once considered temporary and an unimportant affection, to-day is recognized as an alarm note indicating the approach or existence of serious

trouble." This may be the initial symptom of zymotic affections or the earliest manifestation of impaired nutrition. The membrane lining the nasal cavity is so sensitive to nervous impressions that irritation there may cause asthma, epilepsy, chorea, hay fever, or other forms of neurosis. A case is reported where coryza appeared, later sneezing, and then spasms of the throat, proving fatal. The laryngismus was beyond control, but the early treatment of the coryza might have ended the morbid tendency. Since we know the nervous character of this affection, and know that such measures and remedies as restore strength and health of nerves bring most permanent relief from this condition, we are strengthened in our resources against future attacks of each individual case.

This age of progress and invention has given us rapid transit by means of cable and electric cars. They traverse every prominent street and some alleys in not only cities and towns, but the village and hamlet not yet honored with a charter of corporation. The noisy revolution of their wheels and clanging of bells have disturbed the children's sleep and rendered necessary quiet and rest impossible. I am certain this influence is a positive injury to many children, yet I am unable to remove the cause, and often doubt that any remedial measures will modify or cure the irritation thus produced on those highly sensitive systems. To expect medicine to make strong their nerves is like holding your hand in the fire and demanding relief from its effects.

It may be a useless reference, but I venture to mention that the use of stimulants and tobacco by parents bankrupt the nervous force and energy of their descendants. Many thus begin life with unhealthy nerves, in the nursery are roughly handled, tossed and jolted about, kept in a constant state of excitement for hours, and if they survive long enough to reach school, there meet influences which rapidly develop chorea or some graver form of disease. A

school-teacher of large experience recently stated that under his observation the school routine had a worse effect upon boys than girls. They seemed more restless under the pressure of long hours, poor ventilation, and little exercise, and more likely to fall victims of acute disease appearing in epidemic form. It is an everyday observation of every general practitioner that many girls suffer from chorea, neurasthenia, or nervous headaches before reaching puberty. The cause thereof may be traced to heredity and environment combined. While we recognize and battle to remove suffering induced by the above influences, we would not forget that important condition generally mentioned first, convulsions. They are always alarming and frequently fatal. They may be induced by an ebullition of anger on the part of the nursing mother, or by shock or fright from the conduct of a cruel, drunken father. They may occur as the first evidence of exanthematous disease, or from the pressure and injury during a difficult instrumental delivery. I am here reminded that the recent demonstrations of Kischensky, Nissen, and Brumer teach us that trismus and tetanus of the newborn may no longer be looked upon as a neurosis, but must be regarded as a traumatic infection; that convulsions, whatever the cause, occur more than twice as often during the first year than any period later up to twenty years. This is due to the difference in the nervous systems of the infant and adult. In infancy the higher brain is imperfectly formed, while the lower cerebral centers are more fully developed; as a consequence an irregular outbreak of nervous energy is the result. Causes which in an adult will merely produce a chill may be sufficient to bring on a convulsion in an infant. Hence the importance of not only restoring a tranquil state of the nerves of that child, but, if possible, giving him a resistive power against a future demand. The sudden call at the time of attack often affords no opportunity of administering curative measures.

But if permitted to be medical counselor, having observations of and acquaintance with the patient for any considerable time, the follower of Hahnemann may hope to fortify the system with such strength that it will resist future spasmodic action.

If it is possible for the patient to secure air, water, and food of pure quality the cure will be greatly hastened. Then by delving among the records of drug provings, or, if necessary, instituting new provings, learn the similia of the diseased condition.

Of course it will take diligent study before one can readily know what to give the case as presented, but you will be likely to secure sleep for the excitable, restless, wakeful child from the use of remedies having these symptoms prominent as keynotes. The effects of fright are relieved and a nervous equilibrium restored with no evidence of drug poisoning. Many nervous children are soothed for the time, and finally made strong, by the continued use of cocoa—not the wine, but in the potentized form. I have had good results from the 3x up.

The remedies usually restoring spasmodic action are well known to you all, but I wish to emphasize the importance of studying the tissue remedies. I have known cases of chorea from eye strain to be cured by mag. phos. 6x and kali phos. 6x. Neurasthenia and eclampsia are also markedly benefited by these remedies. The continued use for weeks of some remedy when the child is considered only nervous may prevent a future interesting case of mental alienation.

## ✿ EDITOR'S TABLE. ✿

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**W**E present in this issue some views on vaccination by Professor Deschere, and some notes on the treatment of smallpox by the editor. The subject of smallpox is attracting considerable attention in all parts of the country. While it can hardly be said to be epidemic anywhere, there have been, on the whole, some thousands of cases during the winter, and the disease has cropped up in almost every State and principal town in the country. While nowhere has it been of sufficient frequency to cause actual alarm, the health authorities have considerable concern as to the future. It is probable that with the oncoming warm weather there will be a great reduction in the number of cases and the disease may die out altogether. But the probabilities are that the germs will lurk in wayside corners to start up again with the frosty weather of the autumn; and it may be that we are on the eve of a great epidemic. It therefore behooves us all to make up our minds as to what we will do if called upon to treat cases of this disorder.

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**A**LARGE proportion of the physicians of the present generation have had but little experience in the treatment of smallpox. The last epidemic we had in this country was more than twenty years ago; although there have been minor local epidemics in various places since. As is pointed out by Professor Deschere, and is well known by all observers, smallpox has always come in waves, and that, now for more than two hundred years, these waves have been further and further apart. In the gradual change of modes of life disease-conditions change also, and smallpox is one of those diseases which are on a decline. This decline began apparently about 250 years ago, and still continues. If nothing is done to perpetuate it, smallpox, like the plague, will die out altogether; lingering like the plague in bye-places, possibly for a century or two, but having little practical effect on the general death-rate.

THERE is no question that smallpox has been kept alive by inoculation. Each inoculated case is a focus of the disease, and although the inoculated person has the disease usually in a mild form, one in a hundred has it severely enough to die of it, and all of them are liable to communicate it to those about them. Although inoculation was lauded in a most hyperbolic manner when introduced into Western Europe from the Orient about 175 years ago, and was practiced very generally for a century, it came to be recognized that it was a dangerous practice, and first France and then England, and subsequently other European governments made it a penal offense. Nevertheless so deeply seated becomes habit, especially among the ignorant, that inoculation is still practiced in the country districts of England in defiance of law, and also to a not inconsiderable extent on the Continent. All that is now said in favor of vaccination was said in favor of inoculation a century and a half ago. It is somewhat amusing to read the literature of the middle decades of the eighteenth century on this subject and compare them with the panegyrics passed upon vaccination in this. It is probably not doubted by anyone who has really studied the subject that inoculation gives a mild form of the disease, and that vaccination gives a still milder form, and that both of them are, to some extent, protective. How much protection this may be in any given case is altogether uncertain. Even when the vaccination takes well it has been shown that the person may be revaccinated again, and again have a typical sore within a few weeks after the first vaccination, and that in some individuals this may be repeated a number of times, and that within a few weeks or months after what is considered a perfectly effective vaccination they may have smallpox, and have it so severely as to die of it. We have even had here in New York a man who had smallpox severely twice within four months.

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WHILE vaccination is to some extent a protection, it is a filthy and brutal practice, as Professor Deschere says, and if we can secure protection to our patients by other means it is our duty to do so. There is no question that, as ordinarily performed, vaccination causes a great deal of suffering and many

deaths. It may reasonably be feared that the widespread prevalence of consumption is somewhat due to vaccination from tuberculous animals. The bovine race is very subject to phthisis, and we are running a great risk in using morbid matter from animals of a tuberculous diathesis. This is a matter that should be considered calmly and dispassionately, and not in a partisan spirit. We all of us desire to do the best possible for our patients. Even if we are selfish and simply wish to get on in the world, it is to our interest to serve our patients to the best of our ability, and if there is any method by which we can preserve them from disease and discomfort which is better than the crude method of vaccination, we should adopt it. Many homeopaths have used the triturated vaccine matter and have claimed for it decisive power. There is no reason why this virus should not be effective in a therapeutic or prophylactic manner, the same as the bee virus or the serpent poisons or any of the other animal products that we have been accustomed to use. Anyone who has had experience with psorinum, carefully used according to its indications, will admit that in that we have a grand remedy in some serious conditions. By analogy, therefore, we can look to variolinum as a hopeful remedy in a preventive of smallpox.

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THOSE who are old enough to remember when lachesis was first introduced will know how much opposition there was, in the homeopathic school, to its introduction. Even yet there are probably some who are prejudiced against it. Nevertheless it has saved many lives, and is the one remedy in some critical cases. Judging by experience, there is no reason why belladonna having proven prophylactic in scarlet fever, pulsatilla in measles, lachesis in diphtheria, that variolinum may not be equally useful in protecting persons from smallpox. Nor is variolinum as a prophylactic a new thing. It has been used for a score of years, and has been approved by men who stand so high in the profession, and who are such successful practitioners, that we cannot ignore their testimony. Of course the allopathic boards of health scorn all these things. They will not admit that variolinum can replace vaccination. Neither would they admit that belladonna



in the 30th or 200th potency would have any effect in a case of scarlet fever, or lachesis or apis or the cyanide of mercury in diphtheria. But are we to permit boards of health to dictate to us what our medical practice shall be? They will attempt to do so, and will do so just as far as we will submit. The Brooklyn board of health has voted not to recognize the administration of variolinum as vaccination, and to require that all children who have been treated by their homeopathic physician with variolinum shall be also vaccinated before entering the public schools.

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WE claim that the homeopathic physician, acting with the consent of the patient, or his legal guardians, has a right to decide on the treatment of all cases. We cannot permit boards of health to dictate to us how we shall treat our patients. If from our experience we think that a certain remedy is the proper one to give under certain conditions, our judgment in that matter ought to be final. If it can be said that having administered variolinum to a person it is still uncertain whether he might not take smallpox if exposed to it, it may with equal certainty be asserted that a person having been vaccinated may possibly take smallpox if exposed to it, because there are many thousands of persons who have taken smallpox within a few months after having been successfully vaccinated. Health boards are everywhere aggressive, and are much more anxious to perpetuate and extend their own power than they are to look after the welfare of the individual. They make oppressive rules which work suffering and loss, and are just as arbitrary as they dare to be. If we permit them to declare that a homeopathic preparation of one kind is ineffective, and permit them to set it aside as of no avail, they will soon advance to the further position that other homeopathic remedies are of no avail, and will claim that our treatment of all contagious disease amounts to nothing, and will, if permitted, seize all these patients and remove them to hospitals under their own charge. This is what they are aiming at. They are trying to do it here in New York. They will do it everywhere they can, and it behooves us as homeopathic physicians to stand upon our rights.

THIS is a very important matter to us as homeopathic physicians. First, let us insist upon our right to treat all the members of the families committed to our care according to our own best judgment. If, after careful investigation, we believe that variolinum is protective against smallpox we have a right to use that form of medical treatment, and no board of health and no authority anywhere can take that right away from us. If we believe that we have in any of our homeopathic remedies a prophylactic against any disease we have a right, and it is our duty, to use that prophylactic in preference to any of the chemical agents or disinfectant methods which allopathic authority seeks to force upon us. The price of liberty in medical matters, as in political, is eternal vigilance. The homeopathic school has weakly permitted the dominant school to dictate to it in the matter of vaccination. Very few physicians, certainly not one in a thousand, have ever examined for themselves the history of vaccination. Those who have done so know that it is a history of a great delusion, foisted upon the medical profession by the frivolous dames of the Court of St. James. It was simply introduced as a sort of patent process for preserving a good complexion. Now that we know how to treat smallpox so as to prevent disfigurement, even this excuse is without reason. The right to vaccinate the public confers upon local boards of health an immense power. They are now endeavoring in many localities to obtain the same power in phthisical cases. When they get this it will be a short step to practically oust the family physician from the treatment of all contagious diseases. Even now, here in New York, they force their way into the presence of alleged diphtheritic and scarlatinous patients for the sake of settling the diagnosis; doing this often in such a brutal manner as to alarm and injure the patient. This is state medicine in a very obnoxious form. We owe it to ourselves and to our patients to protect them against such an un-American procedure.

## NOTES ON CURRENT LITERATURE.

It is within the memory of many now living when it was said somewhat sneeringly, and yet perhaps not together unjustly, "Who reads an American book?" That is no longer said. When the writer became a practitioner of medicine, the same might have been said in regard to special works of medicine from a homeopathic standpoint. There were a few books, such as Marcy and Hunt's "Theory and Practice," Jahr's "Forty Years' Practice," and Hughes' "Manual of Therapeutics," then in its first edition. But that splendid line of special works on homeopathic medicine which we now possess had not then even been begun to be written. Among the earlier of these was Guernsey's "Obstetrics," a book that yet remains a fount of knowledge to everyone who assumes to practice in that department. The latest addition is the noble volume on gynecology which Professor James C. Wood, who for many years was professor of diseases of women in the University of Michigan, and who is now connected with the Cleveland Medical College as its professor of gynecology, has given to us.\* It is a work so thorough, so accurate, so up to date in every particular that we as a school may well be proud of it. It may replace and ought to replace in our homeopathic colleges the text-books on gynecology from allopathic sources. It completely covers the entire subject, as far as this can be done in one volume of convenient size. Its style is succinct and vivid, its description of operations clear and comprehensive, its application of homeopathy to the treatment of female diseases effective and ample. It is splendidly illustrated and beautifully printed, and the text is illuminated by nearly one hundred cases which add greatly to the effectiveness of the work. It would not be possible for any worker in gynecology to write a work that would be perfectly satisfactory to all other specialists in this department. There is always room for criticism, and this criticism will be to some extent deserved. There is an allowable margin of difference in technique, even among the most experienced operators. They can always be,

\* A TEXT-BOOK OF GYNECOLOGY. By JAMES C. WOOD, A. M., M. D. With 210 illustrations, 8vo, pp. 858. Philadelphia : Boericke & Tafel, 1894.

also, a proper difference of judgment as to where the line shall be drawn between medical treatment and operative. A man cannot write a book without drawing this line more or less distinctly for himself, and will naturally expect a reasonable amount of criticism ; but if there is anyone, and we think we could mention names if we chose to do so, who thinks he can write a better book than Professor Wood had done, we can only say to him, Proceed to do so. We shall be very glad to have such a book. Meanwhile we must earnestly commend to the powers that be that Professor Wood's book be made the basis of study in our homeopathic colleges until the time arrives when we have something that is obviously better. Only those know how difficult it is to produce a work so admirable as this text-book of gynecology is who have themselves tried the task, either in this special line or in some collateral one.

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#### MEDICAL AND SURGICAL NOTES.

NITROUS OXIDE GAS is now being used in general surgery and is growing eminently satisfactory. It has been an almost universal belief among the medical profession that nitrous oxide is useful only in cases requiring brief periods of anæsthesia, such as pulling a tooth or opening an abscess. But it has now been found to be equally desirable in major operations, such as amputations, requiring half an hour or more for their completion. The rapidity with which patients reach the state of surgical anæsthesia under its use, its freedom from the historical horrors associated with chloroform and ether, its pleasant effects while consciousness lasts, the quick recovery from under its influence, and the complete freedom from nausea are all commendable features. More important than these, however, is the fact that it is less dangerous than ether or chloroform. It is, also, often an advantage to let the patient come up from under the influence of the anæsthetic for a few moments. This can be done while using nitrous oxide, and without causing any appreciable delay in the operation, because the patient can be so quickly put under its influence again. This is not possible with any of the slower anæsthetics.

A SINGULAR METHOD OF INFANTICIDE was reported at a recent meeting of the Medico-Legal Society of Paris. An infant of five months died without having shown any symptoms of previous disease. Nevertheless suspicion was aroused and the body exhumed some months after burial. No traces of poison were discovered, but the intestines were found to contain some eight pieces of a blackish-gray substance which completely blocked the passage. Careful examination showed that these pieces were sponge, and Professor Caseneuve gave it as his opinion that they were administered to the child for the purpose of killing it. This opinion was founded partly upon the fact that the pieces of sponge presented a smoothly cut surface, and also upon the knowledge that in certain parts of the country the custom prevails of killing stray dogs by placing in their way pieces of sponge soaked in grease, which when swallowed swell up inside the intestines and so cause death. The jury accepted this view and in consideration of this, and other circumstances in the case, brought in a verdict of guilty.

INSANITY FROM THE ABUSE OF INDIAN HEMP is well illustrated in the "running amuck" by the Malays. This irresistible impulse to kill is one of the characteristic symptoms of intoxication from this drug, and it ought to prove useful in small doses in those forms of mania which develop the homicidal impulse and attempted suicide. The use of Indian hemp is one of the common vices in India, where it is recognized as a very prolific cause of insanity. The vice is almost entirely confined to the male sex and to Hindoos; Mohammedans being rarely addicted to it. The reason why the abuse of Indian hemp is confined to the male sex is that the female sex do not get a chance to use it. The male member of a Hindoo family is the head of the house, and enforces his position as such with a big bamboo stick. Unfortunately, the use of Indian hemp as an intoxicant is gradually spreading, and has become a serious evil in British Guiana, the West Indies, Trinidad, Algiers, and is not unknown in this country. There is a close resemblance between the chronic effects of the abuse of Indian hemp and those arising from the abuse of alcohol.

# THE HOMEOPATHIC JOURNAL OF OBSTETRICS, Gynecology and Pedology.

EDITOR, GEO. W. WINTERBURN, M. D.

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## RECENT PROGRESS IN GYNECOLOGY.

BY

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KANSAS CITY, Mo.

[T is impossible to ignore the great prominence which gynecology has assumed in the medical world. Its rapid progress is due to cleanliness, the invention of new operations, and the rational medical treatment of women, as directed by Samuel Hahnemann. To avoid infection of the wound is now of greater importance than to operate brilliantly. In surgical gynecology cleanliness has overcome all opposition, except operative excesses, into which bold and careless operators continue to fall. We are daily reminded of the sacrifice of careful clinical study of the disease to operative measures. An exact interpretation of indications, and a more solicitous exhibition of the simili-mum, would raise gynecology still higher in the healing art. The missing link in the gynecological chain is found in homeopathy.

The allopathists are slowly recognizing the weakness of their treatment. They now say "not only less and better surgery, but more radical therapeutics should be the aim of all modern gynecologists. The therapeutics of gynecology is practically limited to the application of boro-glyceride tampons, and the ordering of hot vaginal douches, along with a few other minor measures. The so-called conservatives, while decrying excessive zeal in surgical interference, seem to have done little or nothing to offset it, but have simply taken their fees in many cases, without giving the patients much, if any, appreciable benefit." (McGillicuddy).

Medical gynecology has received a new impetus since the advanced and most conservative operators have advised that surgical measures should not be adopted so often. It is a noteworthy fact that in the old school of medicine one extreme has often followed another, and that truth, or a portion of it, has usually been found in the golden mean. The homeopathic gynecologist has the advantage of his allopathic competitor in medical treatment, which is by Hahnemann's method an exact science. It is to be hoped that homeopathic therapeutics will be generally adopted before another decade; and that all suffering women thereafter will first receive careful homeopathic medication before submitting to the surgeon's knife. The advances in abdominal surgery have been marvelous, and under aseptic principles the peritoneal cavity can be entered without serious results.

The evolution of a successful method of removing fibroid tumors of the uterus has occupied the minds of gynecologists for the last few years. The degenerative changes which have been discovered in fibromata or fibro-myomata take from them their benign character. After the menopause sarcomatous or cystic degeneration is liable to take place, or a necrotic process may set in, leading to absorption and septic infection. Electricity cannot be depended

upon to dissipate a fibroid tumor. On the contrary, the worst complications are found in cases that have been treated by electricity. The final treatment of uterine fibromata is surgical, and should aim at the removal of the neoplasm itself; and when the tumor is large and the uterus is involved hopelessly, total hysterectomy is recommended.

The ideal method of abdominal hysterectomy is described in the November (1893) number of the *American Journal of Obstetrics* by Dr. Geo. M. Edebohls. It is recommended only when a vaginal hysterectomy is impracticable.

Gynecologists have shown that the vagina is the best channel through which the womb should be extirpated, whether for cancer, for incurable prolapse, or for fibroid tumor, if not too large to be delivered through the vagina and vulva. Vaginal hysterectomy for uterine cancer is a safe operation, if the vagina is not implicated, if the disease has not progressed into the broad ligaments, and if the womb has not been fixed by adhesions.

The early treatment of carcinoma uteri now consists in treating cervixes liable to become cancerous, and thus preventing the formation of this neoplasm, and in detecting cancer of the cervix at a sufficiently early date to successfully eradicate the disease. The testimony of many operators is to the effect that they are surprised at the small amount of shock sustained by their cases of hysterectomy, and that the removal of the uterus, with its appendages, shocks the patient less than to remove the latter alone. This fact is supposed to be due to the removal of the terminal nerve filaments of the inferior hypogastric plexus of the sympathetic. If the appendages are to be removed, the uterus should also be removed; for, without the appendages, it is not only absolutely useless, but often becomes a menace to the system.

Vaginal hysterectomy as performed by Dr. E. H. Pratt is



undoubtedly the best method for the removal of the uterus yet discovered, and reduces this operation to one of minor importance. The ideas of the medical profession regarding uterine extirpation and laparotomies are undergoing a radical change. Battey's operation will soon become obsolete, clamps will be laid away on the upper shelves, with all kinds of pessaries, supporters, and instruments of torture, as relics of barbarism; and the ligaturing of the broad ligaments in vaginal hysterectomy will be abandoned. The great loss of blood, the immediate shock, and the nerve pinching involved in the old method of operating, are rendered unnecessary by the new process of dissecting closely to the body of the uterus.

Since the practice of excision of the ovaries became so fashionable, the empirical treatment of nervous and mental diseases has received a new impetus. No organic nervous disease was ever cured by oöphorectomy. Specialists have had a vague idea of the particular degree to which the ovaries enter into the production of nervous disorders, and never till now have a few of the leaders in advance thought discovered that the uterus, as well as the ovaries, must share the responsibility of the profound upheaval of the functions of the cerebro-spinal and sympathetic systems so frequently met with, and that there is no good reason for the removal of the ovaries without the removal of the uterus. It is no wonder that insanity so often follows the removal of the uterine appendages. Let the medical profession study uterine pathology more carefully, and understand what its relation is to the sympathetic system. It has been ascertained, from observations of a large number of women who have continued to suffer after the removal of the ovaries, that the removal of the uterus also, in each of these cases, would doubtless have been the best method of dealing with one of the common sources of pain to the patient and disappointment to the surgeon. In the majority of cases in this class, it will be found that inflam-

mation has been established not only in the tubes, but also in the endometrium and in the canal tunneling the uterus and leading to the tubes.

A few of the most progressive gynecologists now agree that the sympathetic nerve controls cell action ; that any disturbance of the latter influences the brain, and that mental disease is, in the majority of cases, associated with pathological conditions of the orifices of the body. A woman passes through definite pathological stages from any disease of the pelvic organs. A lacerated cervix, or endometritis, or hemorrhoids may be the pelvic irritation which is conveyed by the ovarian and hypogastric plexuses to the abdominal brain, and from there, over nerve tracts of least resistance, to the stomach, intestines, liver, heart, spleen, and other viscera. She begins with a pelvic irritation, which is followed in succession by indigestion, mal-nutrition, anæmia, and possibly a neurosis or a psychosis. Reflex action through the abdominal brain, starting doubtless at the periphery of the hypogastric plexus, interferes with the rhythm of some viscus, and the woman starts on the downward road of ill health. The sympathetic, or ganglionic, nerves supply chiefly the viscera and blood vessels whose motions are involuntary, but reflex disturbances are executed physiologically along these lines.

The greatest and most recent progress in gynecology has been made by the orificial philosophy. No gynecologist who is not blinded by prejudice will fail to see that the dark places in his specialty have been lighted up by the wonderful revelations of the physiological action of the great sympathetic system of nerves, and by the orificial principle that the irritation of an organ starts at its mouth. Not since the death of Dr. Marion Sims has any gynecological teaching been so pregnant with discoveries of truth as that of Dr. E. H. Pratt. The principles of orificial surgery have been verified by hundreds of surgeons, and no progressive and candid man in the medical profession will deny

that orificial surgery has solved many difficult problems in gynecology.

It is known that all the pelvic organs are held in close relationship by the sympathetic system of nerves, and that any one of these organs may suffer by metastasis. The last inch of the rectum deserves as much attention as the cervix uteri, and it is strange that gynecologists should have been so slow in recognizing this fact. What is known as the "American operation" is a great boon to humanity, and the author of it deserves to be held in grateful remembrance for all time. The orificial philosophy has solved the great mystery in many forms of mental aberration, and soon no person will be adjudged hopelessly insane who has not received all the benefits that orificial surgery affords. This statement will be ridiculed by those who are ignorant of the better way; but the handwriting is on the wall, and God is speedily coming to the rescue of his unfortunate people who are imprisoned in the mad-houses of the world. This great reform in the treatment of the insane will be powerfully supported by the disciples of Hahnemann, and homeopathic remedies will go, *pari passu* with orificial surgery, to the relief of nervous irritation and mental derangement. It has already been proven that sexual irritation is the cause of insanity in women, and orificial surgery and homeopathic medication are alone sufficient to restore the functional equilibrium of the cerebro-spinal and sympathetic systems, and bring order out of chaos in nine-tenths of all cases. In the name of science and humanity we are in duty bound to give to insane women the same chance of relief from sexual and rectal irritation that sane women have, and to this end we must press on till we have scaled the walls of asylums and prisons, and liberated, as far as possible, the oppressed of the earth.

Many of the old methods of procedure in gynecology have been proven worthless or dangerous. Intra-uterine applications and tinkering have been condemned by the

teaching of experience. A retained placenta or a neglected abortion should be promptly dealt with, and all decomposing particles or *débris* should be removed from the uterus by the curette, if not otherwise. Accurate diagnosis is now insisted upon before operative measures are resorted to; and a gynecologist who cures a uterus to remove shreds of *débris* or *decidua* and arrest prolonged hemorrhage, should know beyond a reasonable doubt that he is not dealing with an extra-uterine pregnancy or suppuration of tubes and ovaries. With pathological knowledge and accurate diagnosis, we shall make less mistakes in surgery. The gynecologist who has a fondness for surgery, and a deficiency in knowledge of pathology and diagnosis, is liable to do more harm than good.

No one is an expert in the diseases of women who cannot determine accurately by digital examination the location of the uterus and its relation to accumulation in the pelvis. He should be able to tell without anæsthetic or speculum or sound whether the uterus is fixed, or movable, or displaced, and what are the size and physical characteristics of lateral masses. A thorough physical examination, in cases of doubt, should be insisted upon, and the subjective signs of chill, fever, tenderness, pain, backache, dysmenorrhea, hysteria, sterility, etc., should be supplemented by objective signs, in order to arrive at an accurate surgical opinion.

Less mistakes are made in abdominal surgery nowadays. The refinements of surgery and gynecology are the result of concentration of labor and thought on practical work. Good operators have demonstrated that diseased, disorganized, and occluded tubes, with retention, never return to health or perform their physiological functions, and that a diseased or occluded tube of one side only may be removed and conception may follow; but when both tubes and ovaries are removed, the uterus should go also with its appendages. Castration on women has been carried to the

extreme limit, and the reaction has set in. Dr. Wm. Goodell advises that an effort should be made to restore a woman's health by other than operative procedures. "Should the uterine appendages be merely adherent, and not intrinsically diseased to any extent, and should there be active menstrual life, we may release the appendages and perhaps remove the more diseased of the two, but not both of them."

It is well known to pathologists that almost all ovaries look more or less diseased on *post-mortem* examination, and that simple serous cysts are of extreme frequency; but plenty of sound tissue nearly always remains, showing how the ovaries could still perform their natural functions. The unfortunate ulterior results of castration in so many cases have led to a careful investigation of its merits and demerits, and the best gynecologists are now practicing greater conservatism in the treatment of the ovaries and tubes.

The clitoris has been found to be "a veritable electrical button," capable of ringing up the whole nervous system when it is pressed or irritated. If preputial adhesions are not discovered and broken up, the constant and profound irritation of the spinal nerve supply renders the woman miserable. The nerve balance can only be regained by the removal of all pathological conditions of the genitals.

Never before has self-infection from the intestinal tract been brought so prominently before the medical profession. The most constant pathological factor among women is chronic pelvic congestion, due to constipation. The habitual engorgement of the rectum and colon, the irritation, the abrasion, and the septic absorption from the retention of large and hardened masses of fæces develop varicose ulcers and hemorrhoids, and cause repeated straining of the folds of Douglas and chronic inflammation of the perirectal tissues, the parametrium, and the endometrium.

Remove the factors to which utero-pelvic disease is due,

by correcting pernicious habits of life, by the physical training of girls, and by avoiding the bad results of parturition. The mistakes of those who practice midwifery are now soon exposed by the aggressive gynecologist, and the result is that better obstetrical work has been done in the last few years. The gynecological surgeon has boldly entered the field of obstetrics, and by closer study of the mechanism of labor, and wise and prompt operative interference, has succeeded in preventing many of the ulterior evils of neglected childbirth. Subinvolution is the first link in the morbid chain of *post-partum* uterine troubles. Avoid this pathological condition, and the woman may escape its direct consequences, which are numerous.

The predisposing and exciting causes of gynecological diseases are receiving more attention from the medical profession. Heredity and modern methods of education are the rocks upon which the great majority of women are shipwrecked. Everything that causes active or passive hyperæmia of the pelvic organs is a source of disease. Insufficient exercise and lack of fresh air vitiate the blood and favor its stagnation in the pelvis. Lack of attention to excretions, modes of dressing, late hours, neglect during menstruation, improper marriage, and legalized prostitution are fruitful sources of disease of the pelvic organs.

Added to all these dangers are abortions, spontaneously or legitimately induced, or brought on criminally to avoid the responsibility of maternity. The more remote effects of all the vicious and wicked habits of women are foretold by every conscientious physician, and no young woman who is willing to follow good advice need fall short of her greatest possibilities in life.

## THE FORCEPS AS A CONSERVATOR OF THE CHILD.

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BY

J. C. SANDERS, M. D.,  
CLEVELAND, O.

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THE predominant conception of the province of the obstetric forceps on the part of the profession, and the universal conception on the part of the laity, are that the instrument is a conservator of the mother, and justified only when her safety is adjudged in peril.

By reason of its possibilities of disaster this is a lamentable misconception of the office of the forceps, and the object of this paper is to correct this popular but erroneous opinion and to urge the use of the forceps for even the exclusive safety of the child; never, however, in disregard of the mother's well-being.

I submit the proposition that a large and careful observation fully warrants, namely, that babes are often born still which might have been saved by the timely and skillful interposition of the forceps.

It is over a distinct class of cases that this proposition is drawn, and this class is that group wherein the natural powers are adjudged and prove adequate for the safe delivery of the mother, but wherein the babes are born *still*—and *still* beyond the power of resuscitation. Though the mother in such case may be made to feel an inexpressible satisfaction in the consciousness of her own safety, still the loss of her expected and hoped-for babe carries with it an undefinable poignancy of grief and sorrow. The responsibility for this loss and sorrow rests, though unsuspected, in by far too many cases upon the hesitancy and temerity of obstetric art. Though there are many factors that enter into the possible causation of still-births, there are only two that are pertinent to this discussion.

The first is the premature breaking of the membranes and an exhaustive waste of the waters. The second is an undue protraction of the parturient process after the membranes are ruptured, though not premature in their breaking, and the waters have largely escaped. Conceding these factors as common in the experiences of the labor process, the wonder to my mind is that still-births do not more commonly prevail than they do. A few moments' reflection on the case wherein the first mentioned factor is predominant, cannot fail to lead to an appreciation of the peril of the child in same. The source of this peril is first, the firm and fatiguing grasp at every pain made upon the child by the immediate coaptation of the uterine muscular walls. Whoever has had his hand in utero during a pain, as in the act of version, and only such a one, can have any adequate idea of the intensity of this force. When we consider the possibility of this uterine contractile force continuing at intervals of only 15 to 20 minutes for hours and hours—12, 18, 24, and even more—is it any wonder the child should be the victim of exhaustion at its birth? A second source of peril is the compression of the cord at every pain. During its continuance the cord, in the condition of the uterus, drained of its waters, could hardly escape from compression, however hidden within the flexures of the child's body; but the compression would be inevitable, should any portion of the cord chance to lie across any of the convex and salient portions of the child. With every compression of the cord there would inevitably ensue an interruption of the life current of oxygenation to the child; and we have only to think of this, repeated at every recurring pain, for the possible hours before mentioned, to form an adequate idea of its imperiling influence upon the vitality of the child. The third source of danger, and a by no means insignificant one, though one not often considered, is the compression of the placental mass between the womb walls, on



which it may be implanted, and the portion of the child's body that may lie in apposition with it. But apart from this there doubtless is exerted a grasping and constricting force upon the placenta by the contraction of the womb wall on which it is implanted. Through these two sources of placental compression there must be exerted a check or restraint on the placental circulation at every recurring pain and a corresponding tax upon the vitality of the child.

The second factor of peril is undue protraction of the labor after *normal* rupture of the membranes. The peril in this group of cases is not so exigent as in the other, yet is by no means inconsiderable. An exhaustive drain of the waters at their first breaking, or subsequently, especially if the pains are severe and frequently recurring, and with but little progress in the labor, would be sufficient to give anxiety for the safety of the child, though the mother should be counted as probably competent for the completion of her labor unaided. There may be enough progress to give encouragement as to this fact, and yet the labor be protracted to a degree to imperil the safety of the baby.

Any heredity of impaired vitality, or a dyscrasia of any kind that might be entailed upon the child, would in the very nature of things intensify the peril, whether under the first or the second mentioned factor of causation.

There is, then, in labor a danger of still-birth that may in no way seriously compromise the mother's safety—a danger that, so far as her competency for unaided delivery is concerned, makes no demand on obstetric art. The demand, then, in such danger is solely for the safety of the child, and under the threat of this peril there is no device of obstetric art that can take the place of the forceps, whether the head or breech is leading, which in the hands of a trained and skillful ministry becomes the child's instrument of rescue, as surely as it is the mother's when her competency for delivery unaided is adjudged inadequate.

## OCCIPITO-POSTERIOR POSITIONS.

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BYL. C. MCELWEE, M. D.,  
ST. LOUIS, MO.

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IT is my object to present a plea for the life of child, and a plea for humanitarianism on the part of the medical attendant. A plea for the use of the obstetrical forceps instead of the cranioclast; for the use of the knife or scissors instead of the afore-mentioned dealer of death. It is not my intention to enter into a detail of the diameters of the fetal head or the diameters of the maternal pelvis. Sufficient is it to know that the problem to be solved is the delivery of a head with its longest diameter in relation to the shortest diameter of the mother—a condition that none of us care to meet, and when meeting it are often put to extremes to terminate happily. I want to make it emphatic that in my opinion craniotomy is never justifiable at this time, as long as we are in any way certain that life exists in the child. Other better, although apparently more heroic measures are at our command, and are ready of access and just as easily performed, more quickly done, and certainly less brutal.

It must be constantly remembered that the use of the cephalotrite is necessarily accompanied by the destruction of life. The destruction of life, whether in the guise of craniotomy or science or necessity, is nevertheless murder; and when a physician advocates the killing of an defenseless child he assumes a responsibility greater than he seems to think; and lays himself liable to the severest criticisms of his *confrères*, as well as the condemnation of God. However much you may shroud the operation in scientific terms, or excuses of expediency, it is nevertheless unjustifiable. It will be understood that this statement is made with no intention of personality, but represents my

individual view of the condition, deduced from personal observation and considerable reading. Now, I have taken the position to interdict in any case the doing of one thing: the solving of a given problem by a certain proposed method. It necessarily remains for me to furnish something better. That something better is forthcoming, in the farthest extreme if you please, in the Cæsarean section, as radical as it may seem to be. I say, I would rather do this operation, and submit the mother to the slight risk of her life and almost certainly save the infant alive, than to certainly destroy the infant and submit the mother to a greater risk than a laparotomy. If something is desired less radical we have it in a simpler and easier thing to do, *i. e.*, episiotomy. Lusk says that this is particularly the favorite operation of the young practitioner and is done fewer and fewer times as he grows older. What takes its place he has left unsaid, and I have no way of knowing. Until something better is shown me I shall advocate the doing of episiotomy, conjoined with the application of the forceps, as the best solution of the problem under consideration. It was argued against this that the wounds healed slowly or not at all; that it took away the natural uterine support and left the woman a subject of backaches and headaches and various aches, and possibly procidentia. Granted for a moment that such a train of untoward symptoms should occur, I had rather be the author of them and hold a toddling, lisping infant by the hand than to rest under the consciousness of the stain of its blood. Happily, in my experience such unfavorable results do not accompany this operation. On the contrary, the wounds heal quickly and nicely, and leave only a small linear scar to mark the battleground in which certainly one and possibly two lives were saved.

This operation was used by Conrad Braun in the lying-in institute in Vienna long before I was born; but, for what reason I am at a loss to know, it is not practiced as

often as it deserves, unless because of its apparent rashness, which seems to me to be the very essence of conservatism. Often the most heroic measures apparently are really the most conservative and benign procedures that can be done. In this instance it does look very unnecessary to freely use the bistoury or scissors, but subsequent developments show that it is the height of benignancy. I suppose I had delivered a hundred patients before ever I met this difficulty; but when I met it, and got past it, I have been always able to recognize it when I saw it again.

I never wanted to meet it again, but during the month of February, 1893, I delivered nine cases, six of which were of this character. Trouble enough was experienced with my first case, but luckily for the patient no laceration of any consequence occurred, thanks to a roomy pelvis, a small head, and easily distensible vulva. The next case was not such easy sailing. My experience in the first case had flattered me into believing that my subsequent experiences would be equally easy; but before I had finished with the second case I was thoroughly undeceived. Laceration terrible and extensive, both of uterine cervix and perineum, were the conditions found after the delivery of the head. Bad as this condition was, it was subsequently corrected by the proper operations at one sitting. The narration of this case affords the very ground upon which the paper above referred to was written, and it was to avoid the calamities detailed that craniotomy was proposed.

Last summer I was called upon to attend a primipara who weighed about eighty-five pounds; was four feet and eight inches tall, and otherwise proportionately small. Upon examination, bimanual and external, I determined that there was a very large fetus to be delivered. The fetal head was in the first position, properly engaged, and the pains were all that, from the standpoint of the accoucheur, could be desired. Hour after hour elapsed with little or no progress. Patience became forbearance, forbearance

became irritability, and irritability was followed by hopeless exhaustion. To make a long story short, I became heartily tired of seeing the woman suffer, and sought to relieve her by the application of the forceps. After a long and strong pull under an anæsthetic, I was finally enabled to bring the head down against the perineum. Pulling harder and longer, I finally got it presented at the ryma vulvæ. At this point it was readily seen that something had to be done, or a worse laceration than is narrated in the case above would occur here. Something must be done, and that quickly. I slipped my scissors between the head and vaginal mucous membrane, including the entire texture of the labia (carefully avoiding the bulb) on each side, and severed the parts engaged. The next instant, the resistance having been overcome, the head was delivered without further trouble. The parts were immediately stitched up with continuous catgut suture, healed perfectly, and woman and child are to-day happy and well.

If it were necessary or even expedient to save life and suffering in a natural presentation, how much more urgent would it be in the case of the malposition! As long as the head presents I take it that it will never be necessary to do a laparotomy; but in case of cross presentation of a shoulder, or whatever position precludes the possibility of delivery by the natural channel, before I would resort to embryotomy I would do the Cæsarean operation, because on account of the perfection of aseptic surgery of the present day the percentage of mortality is so low as to be scarcely worth mentioning. One word as to the general application of the forceps. Here again what appears or might appear to be unpardonable rashness and vicious meddlesomeness often proves to be the most benign conservatism. I cannot reconcile myself to see a patient suffer four hours or two hours or one hour when I can relieve her in ten minutes.

## OBSTETRICAL OBSERVATIONS.

BY

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EXCEPT as they relate to obstetrics, the three thoughts presented herein are not connected.

Six years ago, in a paper presented to the Illinois Association, I called attention to two classes of mothers and children—the classification based on nutrition:

First, the mothers whose nutrition is so good during gestation and lactation that they are plump, strong, vigorous, and happy. Their children are the opposite—scrawny, weak, with indolent recuperative power, and exceedingly irritable.

Second, the condition of the mother and child is reversed; the former pale, thin, nervous, and so languid that it is a great effort to exert herself; the latter with all the subjective and objective symptoms of a healthy child.

The mother of the first class wonders why the child is so feeble and cross while she is so well; of the second class, why it is so plump and good while she feels so poorly. It is due to the unequal distribution of nutrition, the mother getting more than her proportion in the one case, less in the other, the child being injured or benefited accordingly. The milk of one lacks in quantity the nutritive qualities abundantly found in the other.

In the second class there is a tendency to abortion, miscarriage, or premature labor, and in many cases *post-partum* hemorrhage, all, I believe, due to the weakened condition of the mother from lack of nutrition. It was stated in the paper referred to that the recognition of this fact had been very helpful in avoiding those accidents, and gave clinical cases showing encouraging results. This knowledge has been so helpful to me that I have presumed in this brief

manner to recall it to you, and give one more case to corroborate previous statements.

CASE I. In this case delivery occurred twice at two months, once at three, once at four, once between six and seven, and once or twice between eight and nine months. The *post-partum* hemorrhage was always so profuse and difficult to control that the room would seem dark to her, the pulse become very rapid, and the face pale and pinched. Every time, in reviewing her condition, I thought it critical. I was notified the first time the menses failed to appear. At other times I had given her such remedies as I thought were indicated, but now I gave her nothing but Murdock's Food, insisting that she take it during pregnancy. Result: patient felt better than during previous pregnancies, period of gestation fully nine months, no *post-partum* hemorrhage, few and light afterpains, rapid convalescence, and healthy child.

I have a hesitancy, probably due to prejudice, in indorsing a proprietary preparation; but I have been unable to obtain as favorable results in the class of cases referred to from any remedy or other food preparation as from Murdock's. For the puny children of well mothers I resort to artificial feeding in connection with nursing. If they still fail to improve and show the proper degree of development I advise weaning. Either the milk is insufficient in quantity, when it may be supplemented by other foods, or it is of improper quality, and hence injurious to the child, who must be taken from it.

CASE II. Was called to attend a woman in her seventh labor. In previous confinements, which were very rapid, lasting not more than two hours from the beginning of the dilating pains until the third stage was completed, she had been attended by midwives. This time, after being in labor for twenty-four hours, she feared something wrong and sent for me. I found pains quite regular and strong. Physical examination revealed the os dilated. Protruding

into the vagina was a flabby, rough mass with a sac-like feel, but entirely too thick and fleshy for the amniotic sac. During the pain the head did not progress, but, on the other hand, seemed, if anything, to slightly recede. My first thought was to use forceps, but being uncertain as to the exact condition and cause, I seized the mass with my fingers and made traction during pain. The result was very satisfactory ; the head immediately engaged the superior strait, and delivery took place in fifteen minutes. The child had been dead long enough for the epidermis to peel by slight rubbing. The scalp had become loosened from the cranium, preventing the uterus from bringing to bear an expulsive force on the head, as it would slightly force down the scalp, while the head would slip back. While I have had a number of cases of stillborn children, I have seen but one other just such case as I have described.

CASE III. After practicing obstetrics for a few years I observed that my cases seemed to lose more blood than they did at the beginning of my obstetrical work ; that more often I found it necessary to use measures to check the hemorrhage, which not infrequently was quite active. I noticed that free hemorrhage was not a common occurrence among cases of which I had knowledge who were not attended by any physician, simply having the services of a nurse. I concluded that in many of these cases the fault was mine in not properly conducting the third stage. I believed that in those women not attended by a physician more time was given to the birth of the placenta.

On the other hand, there was a growing disposition on my part to expedite matters at this stage. By taking more time when there was no necessity of immediate delivery of the placenta, I found a marked decrease in the number of cases having an undue loss of blood. After the body of the placenta is delivered, it is often found that the membranes extend into the uterus, which so firmly clutches them that quite a little traction may be made before



they are released. By following with two fingers the membrane into the neck of the uterus, making abdominal pressure over that organ with the other hand, the membrane is released and at the same time all clots removed from that part of the organ by swinging the fingers around the inside. This practice resulted in a still further decrease in the number of cases which required measures to check hemorrhage.

I believe that many cases of *post-partum* hemorrhage of passive nature are due to small pieces of membrane or clots remaining in the neck of the uterus; for since the adoption of this method of removing the membranes the percentage of cases of hemorrhage occurring under my care has been greatly lessened.

I felt no little anxiety after the toilet of the patient had been made to know whether or not she was losing too much blood, and still did not wish to make ocular examination of the napkins or frighten her by occasionally inquiring if she felt much discharge. I found that this information could be accurately obtained in most cases by watching the pulse, which, if it gradually increased in frequency, was an almost sure indication that too much blood was being lost.

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## OBSTETRIC SURGERY.

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BY

WM. C. RICHARDSON, M. D.,

ST. LOUIS, MO.

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OBSTETRIC surgery as a science and an art is to-day fully up to the high standard that has been reached by general surgery through the wonderful improvements made in the past ten years.

When we stop to consider the exceedingly unfavorable circumstances under which most obstetric surgical pro-

cedures are undertaken, it is a matter of great surprise that such splendid results are obtained. A recent author, in referring to the mortality rates of gastro-elytrotomy, states that a large proportion of the cases were not operated on until after the death of the fetus, and in some cases not until so long after death that decomposition had set in.

What has been said in regard to this operation may be said with equal truth in considering the larger number of, if not quite all, obstetric operations.

Up to ten or fifteen years ago the now common application of that most beneficent instrument, the obstetrical forceps, was considered a most serious operative measure, to be undertaken only as a *dernier ressort*; and how many poor women have been sacrificed or rendered chronic invalids by this monumental folly and prejudice!

The accoucheur should always be prepared and ready to use the forceps intelligently and early in every case where indicated.

Among the minor operative procedures that are now undertaken at once after the primary lesion, may be mentioned lacerations of the uterus and perineum. Up to a few years ago it was thought that lacerations, particularly of the cervix uteri, should be postponed till after the puerperal state, and then be repaired by a secondary operation. This is all different now, and the obstetrice who is up with the times immediately repairs, and successfully too, all these lacerations before the lying-in toilet is completed. .

There are many operations, as that of symphyseotomy and Cæsarean section by the methods of Saenger and Porro, which are almost always undertaken long after the most favorable time has passed. The general practitioner too often has failed to inform himself of the pelvic deformity that precludes the delivery of a living child by the natural channels, and often aids to bring about complications by the injudicious use of ergot or the forceps. Yet notwithstanding all this, the operations of gastro-hysterotomy

show a percentage of recoveries that compare favorably with ordinary laparotomies.

The intelligent but not officious or pernicious use of aseptic and antiseptic measures has been of untold benefit to the successful obstetric surgeon.

While on this particular subject I wish to say that in my judgment it is a mistake to shave the pudenda and flush the vagina of every parturient woman with strong solutions of bichloride of mercury and other so-styled antiseptic drugs.

The vagina of a healthy woman is naturally in the great majority of instances perfectly aseptic, and it is folly to do more than observe the rules of scrupulous cleanliness. The use of a filthy syringe too frequently introduces the deadly microbe to the normally healthy and aseptic vagina.

Where there are conditions that demand antiseptic measures they should be resorted to with the same care and restrictions common to general surgical practice.

The lowering of mortality rates in obstetric surgery may be attributed to many causes, among which is cleanliness or, if you prefer, call it asepsis, to improved instruments, new and simple operations, performed by skilled practitioners with improved technique. The most potent factor, however, in lowering the mortality rates is a general beneficent disregard, all along the line of intelligent practitioners, of the old policy to leave everything to nature.

How often has ignorance hid itself behind the old bugaboo cry of meddlesome midwifery!

Among educated and skilled obstetricians it is too well known that most of the terrible lesions encountered are the result of waiting for nature to do impossibilities. Nature can never carry a fetal head of four inches diameter through a pelvic canal of two inches diameter. When our good old-fashioned doctors encouraged this, the result was rupture of the uterus, craniotomy, or some other killing operation. Very often by means of episiotomy, the simple incising on either side of the vulva of a small notch, a com-

plete rupture of the perineum is saved. To the unskilled this may appear as an uncalled for operation, and yet the conscientious experienced practitioner would rather make a dozen episiotomies than have a single complete rupture of the perineum to deal with.

Without attempting or desiring to write a panegyric on obstetric surgery, let me say briefly that we have reached an age when through an enlightened art the process of parturition is largely robbed of its terrors.

The lives of both mother and child are successfully sought to be saved by means of intelligent diagnosis and early operations wherever indicated.

By means of proper hygienic measures, the use of anæsthetics, and the practice of skilled surgery, labor, if not always a physiological process, as it normally should be, is at least rendered one of the most painless, safe, and easily managed of all the conditions demanding our attention.

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## PUERPERAL FEVER.

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BY

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THE definition of puerperal fever is given by several authorities as a continuous fever following confinement. Personally I must say that the term seems unfortunate; as unfortunate a term as "la grippe." I believe that every practitioner has found that a great many of the medical profession, as well as the laity, have used this term, "la grippe," "to cover a multitude of sins," and to include under it conditions which have been in the past and should be still specifically named. So in everyday practice we find the laity always and the profession largely calling by

the name puerperal fever affections of childbed which might be more specifically named. The history of this disease is as interesting as a novel, as full of mystery as the wanderings of a "Brownie," and indeed is the "Will-o'-the-wisp" of the profession. As proof we might go back many decades and trace it down from the memorable case of Dr. Meigs of Philadelphia to within a very few years, and find nothing but a mysterious disease, a superstitious public, and a frightened profession. In the ætiology of the disease has been the mystery, but thanks to the development of antisepsis and asepsis, and the common-sense theories which, though perhaps not partaking of the "germ" theory, are the result of it, we are, I believe, at this time enabled to do away with the superstition and the mystery of our fathers, and even of our teachers of but a few years back, and call puerperal fever an infectious rather than a contagious disease. In doing this we define the present position of the medical profession; in other words, the origin of puerperal fever is doubtless sepsis due to the absorption of septic matter by the endometrium, or some abrasion or laceration along the vaginal or uterine tract. It has also been a favorite theory of mine, as some of you may know, that we frequently get a condition similar to what is commonly known as puerperal fever from an inactive condition of the bowels, and as a result of this the absorption of ptomaines from the colon.

In looking up the literature of the subject recently I was very much interested to find that Dr. James H. Etheridge, as well as many others, has expressed the same belief. The morbid anatomy of this disease is practically the same, according to the cause of the individual case, as that found in septicæmia or pyæmia. Thus we find that the morbid anatomy confirms the present belief as to its origin, and as we go on in the study of the subject we find that the course of the disease is confirmatory. The course of the disease, or the symptomatology, varies very widely. The first symp-

tom is usually, not always, a more or less marked chill, followed by a rise in temperature. This usually takes place from two to four days after delivery, sometimes earlier; very rarely, in plainly marked cases, later. With this rise in temperature there is an especially marked increased rapidity of the pulse. This pulse is inclined to be quite characteristic of puerperal fever, usually more rapid and with less tone than with other diseases of the same temperature.

This feature of the circulation is usually quite persistent, more so than the temperature. The temperature may vary from  $102^{\circ}$  to  $105^{\circ}$ . In severe cases it usually holds high—from  $103^{\circ}$  to  $105^{\circ}$ —though subject during the full course of the disease to sudden fluctuations. If it be a case of pyæmia proper, chills may be quite frequently repeated, giving us to expect new foci of pyæmic infection. If it be properly a case of septicæmia, the temperature is more inclined to remain steadily high with less marked fluctuations in temperature. Early in the disease the mammary secretions usually become lessened and frequently entirely suppressed. The lochia may or may not become lessened, but it is sure, sooner or later, to become fetid; this sometimes being caused simply by the intra-uterine decomposition which comes from the high temperature. There is nothing more variable in the course of the disease than the condition of the tongue. The tongue may be heavily coated, gradually growing dryer and dryer until we have an almost typical typhoid tongue; or it may remain moist and most innocent in its appearance, even down to death's door. There is probably no condition in which we sometimes find the tongue more normal in appearance when fatality is so near as in this disease. We usually find more or less tenderness over the abdominal and uterine regions, sometimes very slight and at other times so exaggerated that the patient cannot bear the weight of even the lightest bedclothing. Diarrhea is sometimes present in our most

malignant cases, and yet many cases go down to death with a condition of constipation. Tympanites usually ensues, and in this symptom I believe we usually find things which are pathognomonic of this disease. I do not believe there is any other disease in which we get the same amount of peritonitis, frequently colitis, and tympanites, with so little tenderness to touch and pressure. As has been said we occasionally get marked tenderness, but commonly the younger practitioner is surprised to find all the symptoms which he has been taught to expect in peritonitis, as decubitus, with the limbs well drawn up and marked tympanites, and yet the patient able to bear the usual weight of bed-clothing over the abdomen. This condition is found, or has been in my experience, in the more malignant cases, and I believe is largely due to the fact that in the very early stages of the disease paralysis of the muscular walls of the intestines takes place, thereby distending the intestinal canal, which causes an early tympanites; and at the same time the nervous centers are so rapidly poisoned by the septicæmic condition of the blood as to cause the very minimum of nervous sensibility of the body. My experience has been, and I believe those present will bear me out in this, that those cases in which this minimum sensibility exists are the most hopeless cases and have the worst prognosis; which fact, it seems to me, would tend to make this theory a reasonable one. As this tympanites continues and passes upward the respiration becomes impeded and at times entirely thoracic; vomiting ensues, which may vary from the sympathetic rejection of the contents of the stomach and possible regurgitation of the bile, to a vomiting of grumous, coffee-ground matter, which indicates a degeneration of the stomach, or what to my mind seems more probable, a degeneration of the blood itself and a loss of its fibrinous qualities, such as we find in snake or diphtheritic poisoning. The skin usually remains hot and dry until the later stages of the disease, when we detect first a

gentle perspiration which gives to the watching friend hope, but to the experienced physician sadness, in that it goes on to a rapidly increasing cold colliquative sweat of collapse. Delirium is sometimes present in a mild, raving form, but most frequently the patient steps from this world to the next with a mind as clear as ever. The urine is usually diminished, although I have known cases where it seemed to be—as in passive congestion from a disturbed nervous system—copious, and of a light specific gravity. In the later stages, however, the urine usually becomes scanty and frequently albumin appears. Let it be remembered that we must not confound this disease with puerperal albuminuria.

We may get in puerperal albuminuria uræmic blood poisoning with an elevated temperature and with all the symptoms that may go with an aggravated case of uræmia, but it does seem to me that we should differentiate between this condition and puerperal fever; and the very fact that everything in the child-bed state that has coincident with it an elevated temperature is sometimes called puerperal fever, leads me to object so strongly to the term “puerperal fever.” If the case be one of septicæmia, this will be the course of the disease. If the case be one of pyæmia, we may have suppuration developing in joints, muscles, or almost any part of the body.

*Prognosis.*—I believe we have a class of cases which develop from the absorption of ptomaines from the intestinal canal, which may be accompanied by sudden elevations and depressions of temperature, a normal-toned, feverish, bounding pulse, marked headache; in other words a sthenic fever in which we may almost invariably have a favorable prognosis. In the usual form of puerperal fever, if the disease is evidenced before the second day after confinement, I think we have good reason to believe that sepsis was obtained from the uterus before the birth of the child, and if this be the case we will have a condition hard to fight and one which



will probably prove fatal. If the disease develops from the third to the fifth day, I believe we will find a disease which, though it may prove fatal, may yet give to us a more favorable prognosis, in that we are called to the fire before the house is consumed. Every day after the third, that signs of septicæmia are evident, I think the records will give a more favorable prognosis, if active treatment be carried out.

*Prophylaxis.*—First, if we have reason to believe, in the last week or so of pregnancy, that the child is dead in utero, I believe if we remove this offending body from the uterus we may save much suffering, and perhaps a life; and yet I am fully aware that we are rarely called upon to decide such a matter, and if we were we would hesitate, even in consultation, upon advising such an unusual procedure. After childbirth our preventive treatment should consist in absolute cleanliness. I believe every case should be examined, before the physician leaves the house, for lacerations of the cervix and the perineum. If a laceration of the perineum exists, repair it and treat it antiseptically; if a laceration of the cervix exists through which absorption may take place, apply the antiseptic douche at least three times a day until all danger is past. If we find upon examination that the cervix and perineum are without question intact, we may use the douche, though I hardly believe it necessary, but would insist that the patient always rise upon the chamber to urinate. This allows perfect drainage from the uterus and vagina; whereas, if the patient is allowed to remain incumbent, discharges may become more or less metamorphosed within the uterus or vagina, and infection take place. It goes almost without saying that no physician should attend a case of confinement without making his hands thoroughly aseptic, and that he should under no circumstances go from erysipelas, scarlet fever, diphtheria, measles, *post-mortem* examinations, or any contagious or infectious disease, to a case of con-

finement, without the most careful efforts at purification that are known to mankind. And right here let me say that I do not believe we should ever consider puerperal fever contagious, but rather infectious. What is necessary for the physician is necessary for the nurse. No one but the physician and the nurse should touch these cases. There is no stronger argument that the methods of prophylaxis are efficacious than the fact that in years gone by we might almost put over the doors of "lying-in-hospitals," "Let her who enters here leave all hope behind"; whereas now, under the practice of antiseptics and asepsis, the mortality has been decreased until to-day it is absolutely less than in private practice.

*Treatment.*—If the case gives evidence of obtaining infection from the intestinal canal, our first duty is to thoroughly empty the bowels by enemata, and if necessary with laxatives; then to immediately render the canal aseptic by giving, after thorough evacuation through a long rectal tube, injections of boracic acid solution. We may also give this by mouth, although I prefer Marchand's glycozone by the mouth. If the disease is apparently, from its early development and other symptoms, one that originated before child-birth, we should attempt to render the intestinal canal aseptic and also thoroughly irrigate the uterus. This, if possible, to prevent any continued absorption, though I am free to say that I do not believe it will amount to much; nevertheless it should not go undone or untried. If the disease develops on or after the third day I believe we can, in the majority of cases, cut short the disease by carefully curetting and irrigating the uterus and following all other antiseptic precautions. I believe this because the danger lies when, prior to this, great absorption or infection has taken place; and by cutting the infection short at this time we are enabled to combat that which has already taken place. I cannot urge too strongly attending to this work on the instant, without an hour's

delay. I have done this and have seen it done successfully so many times that I believe I have abundant reason for stating this as emphatically as possible. The nourishment should be liquid and easily assimilated. I do not believe in giving stimulants in the early stages of this disease. There comes a time when it may be they are a last resort, but I am inclined to look upon them as a last resort rather than as anything to be depended upon in the early stages. I cannot speak too highly of the use of glycozone in all cases where there is evidently marked septicæmia or in which vomiting is a marked symptom. It is hardly worth while for me to give the ordinary indications of homeopathic remedies, for we all know them; and yet let me assure you that I do not undervalue them, for I believe that in our school we are able to save many a case by being able to combat infection which has already taken place, which under the treatment of any other school would die.

The remedies which I would suggest as usually indicated in this class of cases would be baptisia, bella., bry., ferr. phos., apis, arsenicum, arnica, hyoscyamus, puls., veratrum alb., veride, hepar, pyrogenium, lachesis, rhus., sulphur, etc.

I would be pleased to give the history of numerous cases which I have seen, with their course of treatment; but I have already been obliged, in order to present this even in a brief way, to use more time than I had intended, and I thank you for your courtesy in extending to me so much more time than is usually given to a paper of this kind.

## CHOREA IN PREGNANCY.

BY

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CHOREA, which is a rare complication of pregnancy, affects primiparæ by preference, particularly those possessing an hereditary predisposition. Barnes was able to collect only fifty-six, and Fehling only twelve additional cases from the whole domain of obstetrical literature.

According to Goodell, the choreic movements are of reflex nature, and are referable to impaired nutrition of the central nervous system, incident to the hydræmia of pregnancy. The association of chorea and organic cardiac disease has been frequently observed, and the discovery in certain cases of fibrous vegetations upon the mitral and aortic valves accounts for the assumption, by some authors, of embolism as a cause of chorea. Barnes discountenances this view, and calls attention to the probable causative agency of myelitis. Terror and other intense emotions may act as exciting causes of chorea. Choreic movements occurring in pregnancy do not differ from those attending the disease in the unimpregnated state. They are usually bilateral. In most cases the muscular contractions manifest themselves in the earlier months of pregnancy, and continue until delivery is accomplished. In rare instances they are arrested at the beginning of parturition. In still more exceptional cases the contractions may either cease before delivery or persist during the *post-partum* state. Transitory albuminuria and diabetes mellitus are occasional unexplained complications of chorea gravidarum, and the phosphates and urates of the urine are present in abnormal abundance. Abortion and premature delivery, due to the repeated succussion of the uterus, are of very frequent occurrence.

Chorea exerts a prejudicial influence upon the course of pregnancy, having interrupted it in about one-half of the recorded cases. Death of the mother resulted in seventeen of the fifty-six cases collected by Barnes. The lethal termination was usually referable to the exhaustion consequent upon protracted muscular exertion, or to hemiplegia secondary to grave cerebral or spinal lesions. The life of the child is less frequently sacrificed, but it is itself often affected with chorea.

The following conclusions, arrived at by Dr. Lever twenty years ago, fully represent the present state of our knowledge in respect to most of the points mentioned. "In conclusion," says this writer, "I venture to submit the following propositions: (1) That pregnancy is occasionally associated with chorea or convulsive movements; with paralysis of various parts of the body, of the extremities and of the nerves of special sense; and with mania. (2) That the varying symptoms of such complications may be produced at any period of pregnancy, but when produced, although modified by treatment, are rarely removed during the existence of gravidity. (3) That the patients in whom these complications exist are women of a highly nervous temperament, of great irritability, or whose constitutional powers have been reduced by some long-continued but serious cause of exhaustion. Lastly: That although in most instances the symptoms will continue so long as pregnancy exists, yet in a majority of cases we are not justified in inducing a premature evacuation of the uterine contents."

*Treatment.*—The treatment of the chorea of pregnancy requires some remedies not usually used in the non-pregnant. If we take it for granted that the choreic movements are of spinal origin, the chief remedies should be cimicifuga, ignatia, agaricus, cuprum, cuprum arseniosum, and viscum album. I believe cimicifuga to be the most potent remedy. I have cured several cases with the tinc-

ture in 5-drop doses every four hours, and with macrotin in one-tenth of a grain doses every three hours. It should be continued for weeks before we suspend its use, even if we see no improvement. The mental state indicating it is one of depression and melancholy.

Ignatia is indicated in those choreic movements which resemble chorea but are due to reflex irritation, or have a mental origin, such as fright, hysteria, etc. The mental symptoms are important—the alternation of weeping moods with those of unnatural liveliness and joyousness; the jerking and twitchings do not entirely cease during sleep. (Dose, 3x to 6x.)

Agaricus has been found useful when there are illusions of sight and hearing.

Hyoscyamine or hyoscine are specific when in addition to choreic movements there is a general excess of motility, a constant desire to be in motion, especially at night, when there is ungovernable mental and bodily anxiety and restlessness. The dose should begin with 1 grain of the 3x trituration. If no improvement is observed in a few days give 2 or 3 grains — the dose to be repeated every four hours. The maximum dose is the 1-200th of a grain three times a day. Illusions of sight, such as seeing bugs, vermin, or hideous faces when the eyes are closed, horrible dreams with waking in a fright, or morbid jealousy, are special indications. When there is hydræmia, paleness, œdema of the feet and debility, arseniate of iron, 2x, arseniate of copper, 3x, or the arseniate of potassa, 2x, are invaluable remedies. The dose is 1 to 5 grains after meals. Viscum album is especially indicated when with the chorea there are epileptiform paroxysms similar to uterine epilepsy. In very bad cases, when the movements are violent and convulsive, depriving the patient of rest and sleep day and night, do not hesitate to give 10 grains of chloral with 10 of bromide of soda every six hours until the patient is quiet. This has been

known to prevent miscarriage and premature labor. In milder cases sulfonal, 15 or 20 grains, given in hot water, will produce a restful sleep of eight or ten hours. Trional — 7 to 10 grains — will sometimes act favorably. Chloralamid will often act better than chloral. The patient should be kept quiet and free from all annoyance and irritation, and the use of tea, coffee, and beef be forbidden.

In a recent case, accompanied with neglected constipation, after unloading the bowels with repeated colon flushing, the choreic symptoms were removed, or subsided, after tablets of phenacetine and salol ( $2\frac{1}{2}$  grains each) repeated every four hours for a few days.

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## INDICATIONS OF UTERINE DISPLACEMENTS, WITH THEIR NON-SURGICAL TREATMENT.

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BY

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THE uterus is situated in the pelvis between the bladder and rectum. It is supported by eight ligaments, two round, two lateral or broad, two utero-vesical, and two utero-sacral, and by the pelvic floor. Physiologically these ligaments are relaxed to admit of the free normal movements of the uterus. They are composed of double folds of peritoneum, with connective tissue between the folds, and some fibers of pelvic fascia.

The round ligaments are an exception. They are composed of muscular tissue, covered with peritoneum. They are round cords starting from either side of the uterus near the proximate end of the fallopian tubes, and leaving the pelvis by the inguinal rings are lost in the labia majora.

The other six ligaments are attached by one extremity to the uterus, and by the other to the inner walls of the bony pelvis.

The pelvic floor is the chief support of the uterus. It is divided into two segments, the pubic and sacral. The pubic segment is composed of the bladder, urethra, anterior vaginal wall, and the bladder peritoneum. It is attached to the anterior and lateral bony walls of the pelvis.

The sacral segment is composed of the rectum, perineum, the posterior vaginal wall, and strong tendinous and muscular tissue. It is attached to the posterior and lateral walls of the bony pelvis. The pelvic connective tissue permeates every part, binding together the soft tissues, and is attached to the bony pelvis. The integrity of the pelvic floor depends much upon this connective tissue.

The malpositions of the uterus are divided into flexions, in which the organ is bent upon itself, and versions, in which the axis of the unflexed uterus inclines in an abnormal degree or direction. We have anteversion, ante-flexion, retroversion, retroflexion, lateral version, and lateral flexion. Each variety of displacement may be indicated by its special symptoms. Many symptoms are common to all forms, and may result from the displacement or from complications of which the following are common: Metritis, ovaritis, salpingitis, atresia, metrorrhagia, cystitis, vesical catarrh, rectitis, rectal catarrh, peritonitis, peri-uterine cellulitis, uterine catarrh, etc.

It is sometimes difficult to decide which was the cause and which the effect, or whether both or all pathological conditions depend upon a common cause.

The symptoms referring to the pelvic organs are: Difficulty in walking and standing, especially the latter; pelvic pain or discomfort, dysmenorrhea, menorrhagia, constipation, painful or difficult defecation, dysuria, tenesmus, etc. Among the reflex symptoms are neuralgia of various parts, especially about the head and eyes, pain more or less



severe in the region of the medulla, sciatica, paralysis, nervous dyspepsia, hysteria, palpitation of the heart, spinal irritation, etc.

When any of these symptoms are persistently present it is always justifiable to make a thorough examination of the pelvic organs. Successful treatment of a displaced uterus would necessitate the removal of all malconditions of the pelvic organs accompanying it.

Besides flexions and versions, we have displacements upward and downward. Ascent of the uterus is caused by traction from above, as from an attached abdominal tumor, or by pressure from beneath, as from a pelvic tumor. As the treatment is surgical, it does not come within the province of this paper.

Prolapsus uteri is usually considered in three degrees. In the first degree the uterus is displaced downward and usually retroverted. In the second degree the cervix descends to the vulva. In the third degree the uterus protrudes partially or wholly through the vulva. This is termed procidentia.

When the patient has not borne children the prolapsus is usually caused by pressure from above, as from tight or heavy clothing, the presence of an abdominal tumor, ascites, fecal accumulations, or from an excessive deposit of adipose tissue within the abdomen. The prolapsus may be caused by traction from below, as from an attached tumor low in the pelvis, or a vaginal cicatrix.

Increased weight of the uterus may cause its descent, especially if the ligaments have become weakened by debility. The increased weight may result from congestion, hypertrophy, hyperplasia, uterine tumors, etc.

Women who have borne children may suffer prolapsus from any of the causes mentioned.

Many cases result from laceration of the perineum, and perhaps of the posterior wall of the vagina, during labor, impairing the integrity of the pelvic floor. During labor

the anterior vaginal wall is so stretched by the advancing head as to be much shortened. If involution is not arrested after labor the tissues will regain their normal tone and form.

In case of subinvolution the uterus, being abnormally heavy, settles down lower and lower in the vagina, dragging down the vaginal walls. The vesico-vaginal wall becomes sacculated, and the bladder descends in cystocele. When the posterior vaginal wall descends it usually becomes separated, leaving the rectum attached in its normal position. Sometimes, however, the rectum also descends and protudes into the vagina in rectocele.

Should the pelvic floor descend the vesico- and recto-vaginal walls, being a part of it, descend with it, dragging down the attached uterus, the ovaries, the fallopian tubes, and the attached peritoneum. The small intestines follow.

In case of procidentia we have a hernia, the outer covering of which is the inverted vagina. This hernia, like a hernia in any other locality, is liable to strangulation. Vesical irritation is caused by the dragging of the uterus upon the neck of the bladder.

Owing to the abnormal positions pathological changes may involve all the pelvic organs. The circulation is impaired, and we have venous congestion with serious results. From displacement of the ovaries we get ovarian congestion, ovaritis, and maybe cystic degeneration. We also have salpingitis and perhaps pyosalpinx.

Peritonitis may result from the dragging upon the peritoneum. The vagina becomes congested and we have vaginal catarrh and vaginitis. In the uterus metritis and cervicitis are often the result of the displacement, and peri-uterine cellulitis complicates the case. We may have catarrh of the bladder, cystitis, and urethritis.

In procidentia the cervix and vaginal walls become inflamed, eroded, and may be ulcerated from friction, and

the mucous membrane of the vagina becomes dry like parchment.

*Symptoms.*—The patient complains of a pain or sensation of weakness in the sacral region involving the sacro-iliac articulation, a dragging sensation or a bearing down, with pelvic pain more or less constant, dysuria, and constipation with difficult defecation. There may be peritonitis, and pain in the ovarian region.

Examination should be made with the patient standing, then in the dorsal position. Some displacements quite marked while standing disappear on lying down.

In prolapsus uteri examination reveals a prolapsed vagina, possibly cystocele or rectocele, or both, the cervix displaced downward and usually forward, the uterus retroverted, and often we find tenderness in the pelvic cellular tissue. It is easy to distinguish the prolapsed uterus from cystocele or rectocele by the presence of the os externum.

*Treatment.*—Replace the prolapsed uterus at once if practicable.

Should the displacement be complicated with peritonitis or cellulitis these conditions must first be removed. After replacing, support the uterus in its normal position by tampons of cotton or wool moistened with medicated glycerine. In local treatment, as well as internal medication, individualize each case.

So far as possible remove all undue pressure from above. No tight clothing should be worn. All skirts should be supported from the shoulders by means of waists. An abdominal supporter may be needed for a time.

Regulate the diet, which should be liberal and nourishing, but not constipating. Meats, fruits, and vegetables are desirable. Bread made of entire wheat flour or Graham is better than that made of white flour. If the bowels are constipated flush them with hot water every day or every other day until the action is normal. The knee-chest position should be taken several times daily.

After all sensitiveness has been removed the uterus may be supported by a pessary. Each physician has his favorite among the many on the market.

The Hodge pessaries, or some modification of them, as Emmet's or Albert Smith's, give good results. Some prefer Hoffman's inflated soft rubber pessary for a temporary support, but the tissues are more tolerant of hard than of soft rubber for continued use.

Careful measurement should be made to ascertain the size of pessary needed. Its length should be equal to the distance from the lower extremity of the symphysis pubis to the posterior *cul-de-sac*, less the width of the finger. When adjusted it should be loose enough to allow the finger to be passed around it.

Pessaries should be used temporarily if necessary, but should be removed as soon as the uterus will retain its position without their aid.

Retroversion is that position of the uterus in which the fundus is posterior to the axis of the pelvic inlet. While the cervix is in its normal place near the sacrum retroversion is almost impossible, owing to the proximity of the sacrum. Some degree of prolapsus must first take place. After the cervix has been displaced downward and forward so far that the distance from the sacrum is equal to the length of the uterus, retroversion in any degree is possible.

The causes of retroversion are the same as those of the first degree of prolapsus uteri. The symptoms of retroversion are a bearing-down sensation, a feeling of weight in the pelvis, and pain in the sacrum and in the sacro-iliac articulation, constipation, difficulty in walking and standing. It may be complicated by congestion and displacement of the ovaries. The uterus may be bound down by inflammatory adhesions, making restoration impossible till the adhesions are broken up.

Diagnosis of the case depends upon a thorough bimanual

examination. All inflammation should be removed before replacing the uterus.

Retroflexion is that displacement of the uterus in which the organ is bent backward upon itself. It usually results from retroversion. It may be caused by pressure from above, or by great weight of the body of the uterus when the walls are soft and flabby. The ovaries are usually displaced with the fundus. They often become inflamed and, in case of peritonitis or cellulitis, fixed.

The fundus uteri may also become fixed by inflammatory adhesions.

In retroversion as in retroflexion the diagnosis can be made only after a thorough bimanual examination.

A prolapsed ovary in the posterior *cul-de-sac* or a tumor in the posterior uterine wall may be mistaken for a retroverted or retroflexed uterus.

The use of the sound would decide the case when practicable, but in case of metritis, peritonitis, or cellulitis it should not be introduced.

*Treatment.*—Reduce the inflammation if any be present. The safest method of replacement is by bimanual manipulation. With the patient in the dorsal position, the limbs flexed, with one or two fingers of the left hand in the posterior fornix of the vagina, gently lift the fundus away from the sacrum. Then with the fingers of the right hand pressed down behind the posterior wall lift the body of the uterus forward. At the same time with the index finger of the left hand in the anterior fornix press the cervix to its position in the hollow of the sacrum.

When the abdominal walls are thick and tense we must resort to some other method of replacement. Place the patient in Sims' position, retract the perineum with a Sims speculum, then with two small sponges in holders passed up in the posterior fornix lift the body of the uterus as far as practicable, then withdraw one sponge and, placing it against the cervix, lift it upward and backward, and hold

it in position till the sponge in the posterior fornix is withdrawn.

Should it be found difficult to replace by this method put the patient in the knee-chest position, when the uterus can easily be replaced if there be no adhesions.

In chronic cases of prolapsus, retroversion, or retroflexion, it will not be possible to replace the uterus by one operation. It must be raised gently, little by little, until at last it is in its normal position. At each treatment raise the uterus as far as practicable, and support it by means of a tampon of cotton or wool, saturated with medicated glycerine.

Among the best medications for local treatment are borax, boracic acid, calendula, cuprum sulph., hydrastis canadensis, hamamelis, iodine, pinus canadensis, and tannin. Sometimes a cerate may be used instead of medicated glycerine, but as a rule glycerine is preferable as it depletes the congested uterus and surrounding tissues.

Vaginal douches are an important factor in the treatment of all uterine displacements and complications. They should be given twice daily at a temperature of 100° to 120° F., the patient being in the dorsal position.

After all inflammation has been removed the uterus may be supported by a pessary till the ligaments are strong enough to retain it in position. Salt sponge baths are an excellent adjuvant.

Lateral versions and flexions are usually due to metritis or to inflammation of the broad ligament, and we often have inflammatory adhesions.

*Treatment.*—Remove the inflammation, and treat like other flexions and versions.

Pathological anteversion of the uterus is that position in which the cervix is elevated above, and the body depressed below the normal level. This position may be the result of peritoneal inflammation and adhesions, of chronic metritis, or of a fibroid in the anterior wall of the uterus.

The symptoms of anteversion are increased weight in the region of the uterus, a dragging sensation, and vesical irritation caused by pressure upon the bladder.

*Diagnosis.*—On bimanual examination we find the anterior wall of the uterus parallel with the anterior wall of the vagina, the fundus depressed near the symphysis, the cervix near the sacrum and elevated. Should there be no adhesions the prognosis is favorable if the cause can be removed.

*Treatment.*—If due to chronic metritis or peritonitis, remove the inflammation by daily application of medicated tampons. When the tenderness is removed an anteversion pessary may be adjusted, which will lift the uterus away from the bladder and relieve the vesical irritation.

Anteflexion is the condition in which the body of the uterus is bent upon the cervix and the flexure does not disappear on filling the bladder. The rigidity of the flexure renders the condition pathological.

Anteflexion may be congenital or acquired. In congenital anteflexion the child uterus fails to develop at puberty. Acquired anteflexion may be due to increased weight of the body, owing to a fibroid tumor near the fundus, to a thickening of the posterior wall, or to atrophy of the anterior wall.

The symptoms of anteflexion are dysurià, dysmenorrhea, and sterility.

The non-surgical treatment of anteflexion is chiefly palliative. Among the remedies which may be indicated in the treatment of uterine displacements and the complications are *actea racemosa*, *arsenicum alb.*, *belladonna*, *borax*, *chamomilla*, *china*, *chin. arsenicum*, *gelsemium*, *helonias*, *hydrastis*, *hyoscyamus*, *ignatia*, *kalmia*, *macrotin*, *nux vomica*, *podophyllum*, *sabina*, *secale*, *sepia*, *trillium*, *pendulum*, and many others.

## DIET IN PREGNANCY.

BY

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THIS subject is of importance both to the expectant mother and the unborn child. It is only within the last few years that much has been known or said about diet and its relations to health. Perhaps Liebig deserves more credit for starting us on a scientific study of dietetics than anyone else.

The chemical relation of foods, and the digestive ferments (thanks to Liebig, Dobell, and Roberts) are now very well understood, and it is clearly the duty of the obstetrician to teach his patient during her parturient period all he can in regard to proper diet, in order that she may enjoy the best possible health during that trying period and give birth to a healthy child.

The food must be adapted to the condition of the patient. If she is abnormally fat, she must be kept from starchy foods and sweets of all kinds, and all vegetables that produce or contain sugar; such as beets, sweet potatoes, etc.

Dr. Roberts says: "If we allow starchy foods, we might as well permit sugar, as the liver turns farinaceous foods into sugar; grape sugar might be substituted for cane sugar, as it is assimilated at once and does not require to go to the liver to be transformed into tissue." We may allow fruits that are acid, and a great deal of lemons, in any way the patient may wish, except with cane sugar. Lamb, veal, birds, and young poultry, and cream and butter as nerve food, must be her principal diet.

After the sixth month, sitz-baths—hot or cold as she prefers—just before retiring at night; hot-water injections



two or three times a week often give relief where there is a full habit and a tendency to rush of blood to the head.

The hardest labors are found in short, thickset women. And the above course outlined will be found beneficial to them.

The thin, scrawny woman will require the opposite treatment to the abnormally fat and muscular woman. She can have all the starchy foods that she craves, and in addition all the animal fats that she can digest; and if animal fats are repulsive to her she ought to take Savory & Moore's Pancreatic Emulsion, a teaspoonful in milk just before going to bed at night; or if she prefers she may take five grains of Fairchild's & Foster's Pan. Extract in milk or water two hours after her dinner. If she will have her skin rubbed hard with olive oil or cocoanut oil every day it will be of much benefit to her health. After the fourth or fifth month sitz-baths are helpful in all cases. The baths may be taken every other night if more agreeable. Out-of-door exercise is very important; horseback exercise is the best in the earlier months, walking perhaps is the next best exercise; and if not able to take either of the above forms of exercise, then riding in an open carriage will do. For a nervous woman I would pursue the same treatment as suggested for the lean and scrawny woman, only I would have her lie down a good deal the last four months of her pregnancy.

A good rule in all cases is never to eat when we are tired, and this applies especially to the pregnant woman. Good refreshing sleep is good in all conditions; but I would not give hypnotics. Such a course would tend very greatly to produce a nervous child, and might cause idiocy. If we have the spine sponged with very hot water after the patient is in bed, it will produce quiet if it does not cause sleep. A good amount of exercise during the day will often aid the patient to rest well during the night.

Mental food is as important as bodily food. In this age

of steam and electricity, if the child is not given an impetus to study before it is born, it may be left in the race to wealth and fame. Good current literature, good books, hopeful, cheerful thoughts, a constant desire to do something for others, will tend very largely to make a splendid child.

By far the most difficult cases of all will be found in weak or diseased hearts. Here the danger is to the mother. She may die in giving birth to her child, or shortly after being delivered. And for weeks, and may be for months, after the birth of her child she will have to be fed with the greatest care. Before birth, if her digestion is good, she ought to have good beef and mutton twice a day, and during the last four months, I would give Valantine's Meat Juice or Bush's fluid beef (Bovinine), in place of solid beef or mutton, unless the digestion is unusually good.

After birth of her child, keep her on fluid diet for two or three weeks. And keep her in bed for a month; the least indiscretion may cause so-called heart failure and death. She may take a few tablespoonfuls of milk every two hours for the first forty-eight hours, when awake; say two spoonfuls at a time. After the third day a little mutton or chicken broth might be given once or twice a day. How often, to the great surprise of the doctor and friends of the patient, heart-clot or embolism and death ensue! The patient perhaps has been dismissed, and allowed to get out of bed and go downstairs to her meals—she eats a hearty dinner and even at the table falls over in a faint, is carried upstairs—the nearest physician is sent for, but in vain; death soon relieves the suffering mother, and the babe is left an orphan. Always watch the heart before birth and after, until it has regained its normal strength. Where the digestion is weak in these cases, I give pancreatized milk; either Savory & Moore's or Fairchild's.

A good rule is always to keep the waste and supply equal; if the patient cannot take much exercise then

eat little. Another is to rest the weak organs as much as possible.

If the stomach is not strong give food that is digested in the duodenum and intestines—starchy foods and fats and fruits, etc.—or if needs be pancreaticized enemas.

If the heart is much diseased the food must be easily digested, and the stomach must never be put on a strain by a full meal. Remember a branch of the pneumogastric nerve goes to the stomach. If the kidneys are much affected avoid proteids as much as you can, especially lean meats. The kidneys will be sufficiently taxed by the waste of the mother's own muscles. Consider the danger of uremia!

In cases of dropsy I have found great benefit from trinitrin,  $\frac{1}{8}$  grain, where there were fear and sleeplessness. I have had one tablet produce sleep. Some of my patients called them their comforting pills. But I would never give trinitrin unless the swelling was very great and difficult breathing; and then you had better put a tablet in one-fourth of a glass of water, and give it in teaspoonful doses every thirty minutes. If this small dose does not bring relief then we can try larger doses. These tablets are made by John Wyeth & Brother, Philadelphia. They also make them in  $\frac{1}{16}$  grain tablets. Nitrite of soda,  $\frac{1}{16}$  grain, also strengthens the heart. I ought to say that trinitrin only gives temporary relief, but this is a great thing to do until we have time to get the indicated remedy. In severe organic disease of the heart and anasarca I have never been able to find "the indicated remedy."

## EFFICACY OF THE SIMILIMUM IN LABOR.

BY

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**CASE I.** Mrs. G., third confinement, complained of violent headache, from occiput all over the head; eyeballs sore; cords of neck stiff; sensation as if head would fly off.

Labor pains were violent; cramps in thighs and calves; os uteri very rigid; extremely nervous and shivering; complained of seeing strange objects; declared the doctor and nurse were her enemies; during the pains, sensations of something tearing in her bowels. Abdomen and thighs were very sore.

The peculiar headache, character of pains, and muscular soreness led me to give cimicifuga (and right here I will assert that I do not very often prescribe this drug). I gave the 200 in water, a teaspoonful after each severe pain. After taking three doses the patient became more tranquil, headache and cramps less severe. I then left to make some calls, and returned in about four hours. Labor was progressing nicely; headache and cramps gone, with regular bearing-down pains. Medicine was discontinued, and in a short time she was successfully delivered of a fine boy.

**CASE II.** Mrs. R., married three years, first pregnancy; pains very irregular—one very hard, then a number of lighter ones; pains in small of back, almost unendurable; crying out in great agony; unable to look up without pain, and sensation of something pressing over eyes to close them; wished to keep the room darkened; very melancholy and sad; thinks she will not get through; has been troubled with gastritis; all through gestation has suffered with her stomach; at times would be very hungry, with

nausea and disgust for food. She was, and had been for months, troubled with vertigo when attempting to rise from a recumbent position; also complained of objects moving up and down before her eyes. She has always been irregular in her menstruation. Scarcely any dilatation of the os. Gave cocculus 6x in some water, a teaspoonful to be given every one-half to one hour, according to the severity of the pains. I returned in three hours and found very little improvement. Brought the 200 dilution with me after thoroughly satisfying myself that I had the right remedy; gave it and patiently awaited the result. After about two hours her headache had disappeared, pains became more regular, os was dilating nicely, and in something over an hour labor was successfully accomplished. I have had cases seemingly as difficult when not finding the similar remedy had caused me much trouble and anxiety as well.

CASE III. A young woman, primipara, light hair, blue eyes, somewhat fleshy; been troubled with asthma, much worse the last three months of gestation; nausea and vomiting in the early months. On being called to attend her I noticed these symptoms—she was sitting up: Breathing very labored, asthmatic; terrible heartburn and excessive flow of saliva; complained of this almost constantly; sacrum very sore and extremely tender; cannot bear to have it touched or lie on it; dyspnoea worse on the least motion; rigid os.

These symptoms I never had met before. I knew of some five important remedies for copious flow of saliva: Iodine, iris, lobelia, mercurius, pilocarpine. The peculiar pain in sacrum I noted as a prominent symptom, but could not associate it with any of the five remedies mentioned. I felt also that the dyspnoea played an important part in finding the similimum. I left sac. lac., agreeing not to be gone over two hours. I immediately repaired to my office and began my search. First iodine and iris were carefully

studied, but found wanting. In lobelia was soon discovered the similia. It has the dyspnœa, the heartburn, the flow of saliva, the vomiting, and also the sacral pains. Under back were these symptoms: Extreme tenderness over sacrum, cannot bear even a soft pillow; cries out if any attempt is made to touch part; sits up in bed, leaning forward to avoid contact with bedclothes. This was enough. I started back with the assurance that if the law of similars was true my poor suffering patient would soon be relieved, nor was I disappointed. The medicine was administered in the 6th potency (the highest I then had). In a few hours the dyspnœa was relieved, much less salivation, and by the time labor pains came on as they should she could lie on her back. When enabled to regain her feet after the birth of her child her sacral troubles had entirely disappeared together with her other troubles, and for four years after remained well. I attended her two years afterward in her second confinement with very little trouble, gelsemium being her remedy.

I wish to ask, How many would have gone and looked the remedy up, how many would have known it without looking it up, and what would those have given who would not have taken pains to look it up?

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## NAVEL DRESSING.

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BY

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IT admits of no question that the objects to be attained by the so-called navel dressing of the neonatus are:

1st. Protection of the skin surfaces about the umbilicus from the irritation of the dessicating and decaying cord.

2d. After the decadence and shedding of the cord, promotion of the closure of the umbilical ring, and thereby protection against the occurrence of umbilical hernia.

For the accomplishment of the first object scorched linen has been used from time immemorial. A section of this from four to six inches square is perforated in the center with an aperture sufficient to let the cord easily through, and this is laid upon the abdomen, and the cord is passed through and laid upon the surface of the linen, which is then folded loosely over the cord from each side. This puts a defensive layer beneath and around the cord, and over this is placed a generous compress of the same material, and the whole is supported by a woolen abdominal band.

This linen and infolding cloth dressing was long ago superseded by the absorbent cotton dressing, the latter being equally aseptic, more soft and compressible, and better protecting the skin upon which the cord is placed, and this dressing is alike supported by the abdominal band. This was my favorite dressing for years.

But there is a better material for dressing the navel than the batting, and this is the lamb's wool. This is the ideal material for the navel dressing, because it is equally aseptic, equally soft as the batting, and far more elastic and cushiony, and in case it becomes dampened by either the exudations of the wasting cord or from the urine of the child, it remains as soft and cushiony as when first applied up to the time of the cord's complete decadence, whether this be four or six days, or even longer.

My support for this dressing is no longer the abdominal band, which I regard as unqualifiedly harmful and an abomination as it is generally used, but two adhesive straps, from four to six inches in length, and one inch in width, and placed transversely, one a little above the umbilicus, and the other a little below, and just in that position which will fully sustain the dressing. The woolen

shirt of the child is all the covering the abdomen needs, and this should be used not for support, but only for *warmth*, for the abdomen of the child should ever be kept warm.

I am confident that the belly-band, so-called, as it is used before and after the shedding of the cord, is responsible for all the umbilical hernias which young babes, and even older children, have been the victims of and suffered from. But this is not all, for it is altogether probable that the inguinal hernias of babyhood, and later, are, in the majority of cases, if not all, chargeable to the persistent and abusive use of the belly-band. It requires but a moment's reflection to recognize the philosophy of this suggestion. All force exerted upon the abdominal front, whether by bandage or otherwise, must spend itself in a counter pressure somewhere—in some direction—either upward against the diaphragm, or downward upon the pelvic contents, or laterally, or directly in front. This reactive or counter pressure will seek, and make itself felt well nigh exclusively at, any point where resistance is least. Where is resistance least in the whole area of possible resistance? Where but at the umbilical ring. Where next least but at the inguinal rings. Whatever direct pressure is put upon the abdominal front of the newborn must, therefore, in the nature of things, thrust the easily movable band into the ring, and thus interfere mechanically with its normal closure. There is no escape from this conclusion.

Let the so-called belly-band of the neonatus, therefore, be relegated to the realm of the obsolete in obstetric art.

After the decadence and dropping of the cord the straps are to be renewed, but placed in the form of a letter X, and centrally over the ring, with a little round ball of the same wool to occupy the navel depression as long as the straps are worn, and these are to be worn until the ring is closed. It will require a far shorter time for the closure of the ring when all abdominal pressure is taken off, or rather, when the



abdominal front is relieved from all the pressure implied by the abandonment of the so-called belly-band.

The Johnson rubber plaster is by far preferable for this purpose to any form of adhesive plaster, for the reason that it is soft, the least irritating to the skin, is most easily applied, is undisturbed by moisture, and adequately adhesive.

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## TWO BABIES.

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BY

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ST. JOSEPH, Mo.

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THE two cases I have chosen to present contain, I believe, some points of interest. The first was to me one of both thought and sorrow. When the child was born (December 11, 1891) the mother was forty years old and the father forty-two. There had been another child seventeen years before who was to all appearances a healthy child, but it died at the age of five years with some childish disorder. Both parents had been in poor health for twelve years before the birth of the second child, the father having rheumatism and being extremely nervous. The mother never recovered her health after a severe attack of spinal meningitis, and she also had uterine trouble. She was very well through her pregnancy ; had a short and easy labor. The child was the most perfect I have ever seen both physically and mentally, talking at nine months and walking at a year. Was unusually healthy, all little ailments yielding readily to remedies. When cutting his first teeth at a year old he had two convulsions of short duration, was circumcised at that time, and never showed symptoms of their return. The mother did not have nourishment enough for him ; cow's milk he could not take

in any form; so he was fed oatmeal prepared to be taken through a bottle, to which a few drops of Bovinine were added; after he was nine months old he was very fond of it and seemed to thrive upon it. At noon, July 29, 1893, he complained of being tired and asked to be taken—very unusual for him.

Diarrhea began soon after. They came at once for medicine. In the night I was called; it had changed to dysentery. Merc. cor. 6x three hours. Opium 2x two hours apart soon controlled the blood, but the frequent stools and tenesmus kept up several days longer. Then two front teeth came through and the bowels were much better, but he was very nervous, turning his head, uttering shrill cries, and continually saying, "Up, please; up, please"; but motion gave him no relief—seemed rather to increase his suffering; did not sleep for sixteen hours. Apis 2x controlled the turning of the head and the shrill cries, but his whole body was in constant motion. I was called hurriedly at 9 P. M., and found him unconscious, whole body cold, and in a profuse cold sweat. His face had the appearance of death; breath slow, labored, and cold. He could swallow. Tried arsenicum, carbo veg., camphor, brandy; we used hot applications, and rubbed him with hot clothes, but all to no effect. Not knowing what else to do, tried a few drops of chloral hydrate and bromide of potassium prepared in a syrup. It was magical. He soon aroused, the sweating stopped, and he breathed easier. In the meantime I had sent for Dr. Keener. He came and suggested veratrum alb., and I added china. We cut two more teeth through. I left at 2 A. M., after giving directions that he should have a little food. Was called again at four; he was vomiting violently. That was controlled temporarily with ice, but continued at intervals for three or four days. Tried ipecac, arsenicum, nux vomica. At last gelsemium seemed to relieve him; then he again began turning his head until the back was a denuded surface.

We kept a soft cotton pad covered with white silk under his head, and used oil on the sore. Hellebore had no effect. Apis aggravated. Then the inside of his hands cracked in every joint, his elbows and knees were raw sores, and his legs were covered with ecchymosis. His feet were cold all the time. Arnica 3x relieved the spots and the sores healed in a few days. He was rubbed with oil several times daily to nourish him. The nausea again increased; he could retain no food until we gave him Imperial Granum, and at intervals a little brandy in water. He was relieved for a few days; then his scrotum swelled three times its natural size; had the appearance of dropsy; seemed very painful, for he cried a great deal. Puls. 2x gave relief, and again for a few days he seemed better. He then began rolling his head, keeping up a whining cry, and drawing his hand through his mouth. Dr. Keener saw him several times with me, and at one of these visits lanced two double teeth. They came through, and the baby improved more than at any time before; appeared to take notice of things around him. (He had never seemed to be really conscious since the night of the collapse.) They took him out of doors, and he seemed to like the change. The nausea, however, was never wholly relieved. A few days and two teeth more began to swell. The nausea was almost continual; much worse just before urinating; could retain no food until we gave him oatmeal as he had had it when well. Three days after the stomach and bowels would fill with gas till it seemed as if the walls would give way. Arsenicum 6x, hot applications, and massage would remove it. Sometimes we would be obliged to insert a small tube in the rectum; the sphincter did not relax to allow it to pass. It returned less and less for two or three days, then there was no more trouble with it; but the nausea was never controlled again. He was emaciated almost to a skeleton. There was never any trouble with the bowels after the first teeth were through. He gradually grew weaker until thirty-six

hours before death, when he became very much distressed for breath—could be heard all through the house like a person with asthma. Arsenicum 6x and opium 2x gave relief, and he lay quietly breathing shorter and shorter for twelve hours, taking no nourishment, till his breath stopped without a struggle.

I may not have given the time of each attack just right, for his sickness was of nine weeks' duration, and I kept no notes. But all through, after the collapse, there were signs of tubercular meningitis. The persistent nausea, the continual relapses, and the dullness of the mental faculties would all indicate it.

The day before the baby was taken sick I lost a patient with phthisis. I went from that house to the home of the baby. The distance was about two miles and a very strong wind was blowing. I did not go into the house, for the family were all sitting under the trees. Could it be possible that I carried the tubercles to the baby, or was it predisposed from its parents, or was it his cutting so many teeth so close together, and the extreme warm weather?

CASE II. Showing the action of homeopathic remedies: The family history on both sides, so far as I could find, was good. The father and mother have the appearance of being unusually healthy people. The mother had been pregnant three times before, but had miscarried every time between the third and seventh month; had been obliged to keep her bed most of the time, suffering intensely from thirst and nausea. Her labors were severe, lasting from twenty-four to forty-eight hours. When she became pregnant for the fourth time, was very unhappy, expecting all her old troubles over again. She put herself at once under my care, coming to me every two or three weeks. I gave her remedies as she needed them, often there being a month or two at a time in which she would need none. At the fourth month there were signs of abortion. I gave

her secale 3x and bryonia 3x. She stayed in bed two days and was quite well again. She would often walk twenty blocks at once, and one time rode in a carriage twelve miles into the country and remained three weeks, coming back in the same way, with no bad effects. When her labor came on, January 30, 1893, I was called at 2.30 A. M., and was obliged to stay at the house only one hour. She had pains only three hours in all, and none were severe. The baby, a girl, weighed about nine pounds and seemed very perfect. The mother made a good recovery and had no trouble, except a little attack of hemorrhoids the third day; that yielded readily to nux vomica 2x and podophyllum 3x. They brought the child to me frequently the first two months. Except her crying a great deal, she seemed healthy. I did not see her again until she was four months old and was shocked at her appearance. Her head measured  $16\frac{1}{2}$  inches around the forehead. She took no notice of things about her; could not sit up nor move her legs: they seemed paralyzed. The mother said her crying had increased and she seemed in pain. An examination revealed an umbilical hernia which protruded enormously when she cried. I had a truss fitted at once, and gave her calcaria carb. 6x four times daily. An improvement began immediately: first, by beginning to notice the people about her, and next, by trying to sit up and use her legs. At the end of three months more she seemed as bright as children of her age. Her head then measured seventeen inches, but never increased after that. At a year she could stand alone and say many words. At her first birthday they removed the truss altogether; the hernia seemed entirely healed. She had several attacks of diarrhea, and at one time was very sick with pneumonia, but all yielded readily to remedies. She still cries a great deal. I have thought that might be owing to her mother's unhappiness during pregnancy. She has been for nearly a year kept on calcaria carb. 6x, with oc-

casionally a little silicea 6x, at first four times daily, but later only twice.

The family, and it is a large one, before this have been much prejudiced against homeopathy, but I think now if their old family physician, to whom they are greatly attached, were removed, they would all favor homeopathy.

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## HYDROCEPHALUS OF THE FETUS.

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BY

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THAT mysteries solved are no longer mysterious goes without saying. There are few positions in which a physician is placed where he is more ill at ease than when attending a case of labor where something is wrong and the attendant is unable to ascertain the character of the abnormal condition. Such, however, was the position of the writer some eight years ago under the following circumstances: Was called at 10 P. M., June 23, 1886, to attend Mrs. B., aged twenty-one, primipara. Pains had been regular for twelve hours. Examination discovered the feet well down in vagina near the vulva. Gentle traction brought the hips through the readily dilating os, and as the body came down the cord was found to be pulseless. After some difficulty we succeeded in bringing the arms down from their position of extension at the side of the head. Everything was in readiness now to deliver the head, the position being occiput right posterior. Knowing the child was dead, we easily passed the index finger of the right hand into its mouth and depressed the chin upon the sternum, making at the same time firm but steady traction on the body with

the other hand. Uterine contractions were firm and strong, and it seemed that every pain would be sufficient to complete the expulsion of the fetus. But it made no progress. I worked and tugged till my strength was near exhausted, and in disgust and almost humiliation sent for assistance. The assistant, an allopath of considerable experience, came, and was going to deliver the child in less time than it takes to read this. But his efforts were fruitless, and after an hour's hard work suggested that we obtain further counsel. My suggestion that we use the cephalic perforator, passing it through the superior maxillary into the cranial cavity, was rejected, and the third man was summoned. He also was an allopath, a burly son of Erin and a whole-souled fellow who had taken his degree at Bellevue. He came, and we explained the case to him, when he laughingly remarked that we two were not big enough to handle a case like that ; and as he took off his coat and bared his big muscular arm I admit that my physical inferiority was more apparent than I had hitherto realized. He declined, however, to remove his paper collar at my suggestion, and proceeded at once to the work of delivery. His success was no better than was ours, and a hurried consultation amid the pleadings of the poor woman, whose agonies of body and mind were almost intolerable, decided to adopt my former suggestion and empty the cranium. As I was in the act of introducing the instrument, assistant number 2 remarked that in passing the fingers up to guide the blades of the knife the fetal head appeared soft. In another instant he had plunged his finger through the orbital depression, a large volume of water gushed out, and I easily removed the child from the mother, who recovered in due time. Medical literature on this subject is not voluminous, and the cases cited are comparatively few.

Mme. La Chapelle saw 15 cases in 43,553 labors.

Merriman saw 1 case in 900 labors.

Lever saw 1 case in 4600 labors.

Kucker saw 3 cases in 12,000 labors.

McDonald and Ramsbothen saw 1 case in 3000 labors.

Professor Charpentier is of the opinion that these figures are too low, as he saw 3 cases in the Clinique in 2000 labors, and had 4 in his private practice. The condition is probably dropsy of the cerebral ventricles, the causes of which are to a great extent hypothetical. In the case above mentioned the body of the child was quite small and the cranial bones were rudimentary or undeveloped. Judging from the appearance of the cranial bag, it must have contained three quarts of water. It would doubtless be difficult to recognize hydrocephalus of the fetus before the advent of labor, as the symptoms are vague and a diagnosis prior to that event scarcely possible.

"One striking factor," says Charpentier, marks hydrocephalus, and this is the association of presentation of the pelvic extremity. While, where the pelvis and fetus are of normal size, the vertex presents in 19 cases out of 20, and the pelvic extremity once out of 70 or 80, in the 28 cases of hydrocephalus collected by Chassinat there were 7 presentations other than that of the vertex. Scanzoni reports four-fifths of these cases other than the vertex presentation. Not until after rupture of the membrane in cephalic presentation would a diagnosis of hydrocephalus be possible. In pelvic presentation everything moves on normally until the head is reached, when all progress ceases. The head will not engage, and the more traction made the greater the difficulty, as the waters are forced upward and form a globular mass, making delivery impossible until the fluid is evacuated. It is here that rupture of the uterus is imminent. In 74 cases of hydrocephalus reported by Kieth rupture occurred 16 times. The prognosis is grave for both mother and infant. An early diagnosis, of course, makes it more favorable for the mother, who usually dies from rupture of the uterus or traumatism during efforts at delivery. Spontaneous expulsion of the child sometimes takes place when



the sac of water is small, and under these conditions the child may survive ; but in a vast majority of cases the infant is dead prior to delivery, or succumbs soon afterward.

Treatment varies according as the presentation is of the vertex or the pelvic extremity. When the vertex presents and the accumulation is slight spontaneous delivery may take place. If the affection is more pronounced the forceps may be tried, and if after a number of prolonged tractions the head does not come down, we should at once perforate the head and extract by the cephalotribe or bone forceps. In case of presentation of the pelvic extremity traction may sometimes deliver, but if the volume of water is large it is only a loss of time which imperils the life of the mother, and immediate interference is imperatively demanded. In our case, as before stated, the tumor was reduced by puncturing the sac through the orbit.

The method advocated by the great Tarnier is to evacuate the fluid through the vertebral canal. An incision is made with a bistoury and a catheter pushed into the cranial cavity. It is my opinion, however, that we would have succeeded by perforating the cranium through the superior maxilla. In doing this great care should be used lest the knife injure the mother. The deduction from the consideration of this form of dystocia is that immediate interference is necessary as soon as a diagnosis is made, that the life of the mother may not be jeopardized ; and that in a vast majority of cases the condition is fatal to the child.

## PRATT'S METHOD OF VAGINAL HYSTERECTOMY.

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BY

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CZERNY of Heidelberg did a good work for suffering and menaced womankind when, sixteen years ago, he revived the operation of vaginal hysterectomy. To Sauter belongs the credit of originating it, but under the untidy methods which prevailed a half century ago it failed of professional approval. The dawn of the antiseptic era disclosed its advantages and possibilities, and a continuously improving *technique* has steadily diminished the resulting mortality.

The original operation was designed as a relief from malignant disease which was confined to uterine tissue, or which, at most, had extended but little beyond it. Later, cases of prolapsus and inversion, and latterly uterine fibromata and intractable endometritis with salpingitis, have been included.

The *technique* of the operation, as I have before hinted, is by no means uniform. Distinct methods and numerous modifications have been introduced, among the former of which we may justly include Dr. Pratt's.

Questions relating to the advisability of including tubes and ovaries in the exsection, of ligating the broad ligaments and cutting them in sections, of stitching the peritoneum to the vaginal walls, of using clamps, etc., have excited much controversy, and each method still has its advocates. Another mooted point is the manner of dealing with the hiatus in the vaginal vault created by removal of the uterus.

Notwithstanding the unreasonable opposition of Lawson Tait and a few other operators of repute, vaginal hysterectomy, now that its mortality has been reduced so low, has unquestionably come to stay, and may be justly regarded as an operation of great utility.

*Mortality of Ordinary Forms of Vaginal Hysterectomy.*—When the old operations of conservative surgery, such as cervical amputation and funneling, disclosed their inefficiency as remedies for cancerous invasion of the uterus, Freund undertook uterine extirpation through the abdomen, but the frightful mortality which resulted constituted the impulse which drove Czerny to seek, and others to find, far better results by the vaginal route. It is interesting to note the great improvement in recent statistics of Freund's operation as variously modified. Under Baer's method, with the patient in Trendelenberg's position, when the cases are not complicated by enormous tumors or extensive adhesions, the fatality has found nearly as low a level as that following vaginal hysterectomy. Zweifel recently reported 92 uterine amputations for myomata, with intraperitoneal treatment of the stump, and a mortality of only 3.2 per cent.

The mortality resulting from vaginal extirpation was at first disheartening, but it steadily sank, until now it is below that of extirpation of the mammary gland.

In order that we may see at a glance the remarkable immediate results of this operation according to accepted methods, I call your attention to the following figures:

OPERATION BY THE USE OF CLAMPS.

Doyen.....	61 cases.	3 deaths :	4.9 per cent. mortality.		
Jacobs.....	149 "	3 "	2 "	"	"
Péan.....	150 "	1 "	0.66 "	"	"
Richelot ..	169 "	11 "	6.5 "	"	"
Rouffart.....	52 "	2 "	3.8 "	"	"
Landau .....	79 "	4 "	5.1 "	"	"
Total...	701 "	31 "	4.4 "	"	"

## OPERATION BY MARCELLEMENT, FOR FIBROIDA.

Péan.....	300 cases.	6 deaths :	2	per cent. mortality.
Richelot.....	39 "	1 "	2.5	" " "
Doyen.....	28 "	1 "	3.6	" " "
Jacobs.....	22 "	0 "	—	" " "
Total ..	389 "	8 "	2.05	" " "

## OPERATION BY SILK LIGATURE.

Thorn ..... 33 cases. 0 deaths.

These are the most recent statistics, and they challenge admiration.

It is interesting to study the progressive improvement which has been going on in the mortality statistics of vaginal hysterectomy.

Before 1877 there had been 33 operations, with 82 per cent. of deaths.

In 1884 the loss had fallen to 33.9 per cent.

In 1887 the loss had fallen to 24.47 per cent.

In 1890 the loss among the best operators had fallen to about 5 per cent.

In 1894 the loss among the best operators stands, as you see, at 4.4 per cent. for clamps, and 2.05 per cent. for marcellement.

The causes of death after the operation are mainly shock, sepsis, hemorrhage, and implication of the ureters. The liability to these is steadily being overcome, and I look forward with confidence to an average death rate among the best operators of only 1 per cent.

It is but just that we should bear in mind that nearly all the cases before tabulated represent operations for relief of real disease involving the organs removed, and in many instances disease which, by reason of its profound constitutional effects, causes traumatism to be poorly borne.

I feel no interest in the controversy over the priority of Dr. Pratt's claims to the method of vaginal hysterectomy recently described by him, though my opinion is clearly enough indicated by the caption of this paper.

The particular method which I stand here to discuss was never discovered by accident, but was evolved out of an intimate acquaintance with the anatomy of the pelvic structures such as only a close student is likely to have. Moreover, I pay the reputed author of it no undeserved compliment when I say that the *technique* has been so simplified and clarified that anyone of surgical tact can readily follow it. In my opinion, this method is as easy of execution as Martin's, which, among the older methods, I regard as one of the best, though more difficult than that with clamps.

*Not well Adapted to Cancerous Cases.*—In Pratt's operation the one essential is to begin and conclude enucleation close to the uterus proper, as only by so doing is the net of cellular tissue in which the vessels lie to be slipped off without extensive blood loss or ligation of bleeding arteries.

But I would have you observe that this characteristic requirement of the operation is the very one which, in my opinion, constitutes its weakness by limiting the scope of its adaptability. At the same time I would not divert your minds from the fact that it was probably intended to be supreme only in a special field, and that including but a part of the territory embraced within the design of other forms of hysterectomy.

Hitherto, uterine extirpation through the vagina has been resorted to chiefly for malignant disease, and the methods employed have all involved section of the vaginal vault and broad ligaments at as great a distance from the uterus as safety to the ureters would allow, which action necessitated severance of both the uterine and ovarian arteries, with some of their branches. When operating for cancer it is evident that the more of the para-uterine tissues we can exsect along with the uterus, the less likelihood is there of recurrence of the anomalous structural changes which necessitate the operation. In Pratt's operation we

are compelled to keep so near the uterus that we are liable at times to plow into the proper tissue of the organ which we are removing. For this reason I opine that its use will be mainly restricted to cases wherein malignancy does not characterize the lesion which calls for operative interference.

*Best Adapted to Obstinate Reflex Cases.*—Now, in view of all this, I am of the opinion that the popularity of this excellent method of uterine extirpation will depend upon the justification which operators may find for so radical a procedure as a means of possible relief from distressing reflex symptoms. I say "possible relief," because we cannot, after all, be sure that the symptoms of nerve irritation which we seek to alleviate will find a cure in removal of the internal generative organs.

*Is the Operation often Justifiable for Reflex Symptoms?*—Dr. Pratt has laid humanity under a lasting debt of gratitude by directing attention so emphatically to the most frequent causes of reflex disturbance, and the best methods of relief; and therefore with respect to phenomena of this nature I heartily accord his opinion ponderous weight. For this reason, when I see him unhesitatingly remove one uterus after another, with its annexa, as a means of relief from such phenomena of an aggravated and aggravating type, I feel inclined to follow his example without question. Yet, my friends, as a conservator of the mental and physical comfort of those who fall to my care, and as one who must answer for the manner in which he uses his opportunities for good and ill, I am constrained to stop to make sure, if possible, that I am on safe ground.

I can say nothing in the way of criticism of the operation *per se*, nor do I feel disposed to do so. Indeed, I regard it as a splendid surgical method, nicely adapted to uteri of normal, or moderately abnormal size. I stand here to question nothing but the character and intensity of the pathology which shall be accounted as a just demand for it.

*Is it a Simple and Harmless Operation?*—It is bound to be wrongly applied in many instances for the very reason that Dr. Pratt has made it seem so simple in execution and so innocuous in nature. I know men, and so do you, who love to associate with the surgery which they do, terrors from which few but themselves know how to escape; but be it said to Dr. Pratt's credit, that his large-heartedness leads him to the other extreme. He has a faculty for making an operation lucid both in description and demonstration. He is an excellent teacher, as all will testify who have been under his instruction. In the spirit of a teacher he is betrayed into saying with respect to this major operation that he has transformed it into a minor one. To me this claim sounds extravagant. His method seems to him most simple, but in point of fact it is more difficult and tedious than hysterectomy by means of the clamp. I hope no offense will be taken at my calling your attention again to the statistics already given which show the clamp method to be safer. You have merely my assurance that it is easier. When this method of Dr. Pratt's has reduced the mortality under the very best operator to a little more than one-half of one-per cent., as it has been reduced by the clamp method under Péan, such a claim will not sound so extravagant.

To show you that I am not magnifying the claims set forth for this operation, permit me to quote a few words from one of the doctor's own reports. "Her attending physician was present," he says concerning a case, "and did not believe me when I assured him that the operation was free from all danger." Such statements I insist are misleading, and therefore wrong. Under the most favorable conditions it is not free from danger. Dr. Pratt has had a mortality of six per cent. for his first hundred cases, and from these the risk is plainly shown. "What is really meant," someone may say, "is that the danger is comparatively slight." Reflect a moment. If one out of every

twenty leaving for New York daily were to lose his life, would not a great wail go up from the people, and justly so? Such mortality would be reckoned a tremendous slaughter.

The claim is also made for this method of vaginal hysterectomy that there is under it no call for ligatures. In practice this proves hardly true. That ligatures are frequently required Dr. Pratt himself will not deny. In applying ligatures and clamps under the older methods it is held that nerves are pinched and much reflex harm is done. It is quite true that when clamps are applied they compress the duplicatures of peritoneum which constitute the broad ligaments together with interposed vessels, a web of cellular tissue and many nerve fibers. But in such cases no stitching is done. In Dr. Pratt's method the peritoneal edges are drawn together with catgut, and the vaginal flaps are spread widely apart and so held by a silk plug. In approximating the peritoneal edges, perfect coaptation cannot be made, and a considerable mass of tissue is sometimes drawn together. In all kindness I inquire, is it not likely that nerves are held in the cicatrices formed by both peritoneum and vaginal walls, capable ultimately of doing as much harm as does an atrophic process, which is said to create so much disturbance in what, both before and after removal, appears to be a healthy womb? Furthermore, in doing so much suturing are not nerve fibers compressed by the stitches themselves?

An important fact in connection with the clamp operation should be borne in mind, namely: the forceps are left on twenty-four, or at most forty-eight hours, and then nature is at liberty quickly to restore vitality and adjust the various anatomical and functional relations. On the contrary, catgut retains its strength for several days, and, of course, suffering nerves are held for a corresponding period.

Now a word with respect to the matter of hemorrhage.



I do not know that Dr. Pratt has lost a patient from such a cause, though I am told that he has, but I am acquainted with one case in which the blood loss was considerable, according to the patient's report, and but for timely attention might have proved serious. There is no question in my mind that this method exposes the patient to unusual danger from secondary hemorrhage and entitles her to careful watching. Primary hemorrhage is sometimes extensive. Dr. Pratt's plan is to cut, and then ligate the vessels which persist in bleeding. Under the other methods the course is first to ligate, or clamp, and then to cut.

In our study of this subject there are other considerations which should not be overlooked. Some weight in many cases, and much weight in some cases, should be given the essential effect of hysterectomy upon the powers of reproduction. At the same time I am in doubt as to the degree to which our judgment ought to be influenced by it. I do not share to a great extent the sentiment which lays a moral obligation upon every woman in wedlock to worship at the shrine of the Goddess of Fecundity. There are many women who are no better suited to assume the responsible duties of maternity than is Robert G. Ingersoll to conduct the solemn services of an orthodox church. There is no doubt that many women curse the world by the exercise of their reproductive powers. Far better would it have been for the many mental, moral, and physical wrecks about us, their parents and the world, had they never been born.

These, fellow practitioners, are some of the counts in the indictment which is sure to be sought against hysterectomy performed mainly on account of reflex phenomena, and they ought to receive our thoughtful attention. I sincerely hope that results, when scrutinized years hence, may convince us of the wisdom of removing the uterus for such causes when other measures fail. But let us remember that present work of this kind is still experimental. It is

a new departure in orificial surgery, but is a procedure of so radical a nature that it ought not to be taken up with as little concern as trachelorrhaphy, colporrhaphy, or perineorrhaphy. Setting aside all other contingencies save the single one of death, still this question deserves most attentive study by all who hold human life sacred, so long, surely, as even two or three, to say nothing of six, faces in every hundred, representing the subjects of this operation, look up chidingly into ours with the pallor of death upon them. The same moral sentiment which stays the hand of the one who would deal a deathblow to a patient painfully and hopelessly ill, on the plea that such a life is not worth the living, should make us at least weigh carefully the moral right to take in hand an instrument, with which, in operating, we are sure to slay, according to the best statistics, two, three, five, or six in the hope that ninety-eight, ninety-seven, ninety-five, or ninety-four may be thereby rendered more comfortable while they live.

Let it be distinctly understood that I raise this question concerning radical operative measures for possible relief of purely reflex symptoms, which, though hard to bear, do not seriously menace life or threaten to unsettle reason. It is not enough for us merely to get the patient's word for it that life is a burden, and proceed, on such a foundation, to assume that we are therefore justified in cutting out, at great risk, what we may term a useless organ, in what will often prove to be a vain hope of relief, while we all the time know full well that by so doing we are scientifically juggling with human life. On the other hand, I will join hands with the most enthusiastic orificialist in taking considerable risk, if need be, when operative interposition points confidently to lengthened days and a sound mind.

Cases have to be decided on their several merits. The environments are dissimilar and the conditions various. Sometimes one element and then another assumes chiefest importance in a determination of the wise course. You

will agree with me that judgment and discrimination are most important factors in the make-up of a truly good surgeon. With these faculties must be associated a nice moral sense; while for faithful expression they all require undaunted courage. To test the sincerity of our convictions it is well to put our own wife, or sister, or daughter, in the victim's place, and then see how we would act. Let that best of all rules called the golden be our rule of conduct in all surgical work, and we will not be likely long to follow a wrong course.

I have no doubt that it will be found truly wise to perform this operation for relief of reflex phenomena in a certain number of cases, but I hold that it should be taken up only as a *dernier ressort*. After an experience in general practice of seventeen years, I find myself still hopeful of relief for such symptoms through the application of various remedial measures of an innocuous nature. Most of these cases are well worth a prolonged and repeated use of massage, electricity, calisthenics, deep breathing, hydropathy, change of climate, varied diet, minor surgical measures, hypnotism, and best of all, the thorough action of our remedies, before removal of the internal genitalia is seriously considered. In truth I would go farther and say that reflex disturbance of a most disagreeable character, which is not likely to shorten life, or which does not menace reason, would better be borne with a deferred hope of ultimate relief rather than that a wife, a mother, a sister, or a daughter, dear to someone, take the chance of cure at so great a risk and so heavy a physical expense.

I trust it is not necessary for me to say in conclusion that I have endeavored to present a rational view of this operation in its various bearings, not from the standpoint of an opponent of orificial work, for I am a believer in it and a moderately frequent operator, but from the position of a conservative surgeon. The fact is that we are in the midst of a surgical cataclysm which is sweeping some of

the best men off their feet; and in this paper, scarcely worth the time which you have accorded it, I merely venture in some interrogatives and ask that we halt for a moment to give them candid consideration.

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### A CONSIDERATION OF GYNECOLOGICAL OPERATIONS AS A MEASURE OF RELIEF IN SOME PERVERSIONS OF THE NERVOUS SYSTEM.

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BY

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A SHORT time ago my attention was called to this subject by a number of cases which came under my observation. I will detail a few.

Miss A., dressmaker, thirty, consulted me in reference to her trouble. She complained of being tired all the time, could not walk or work; constant pain in the back or limbs; was nervous, wakeful; suffered from cold feet, etc. She also said that there was a retroversio uteri which was in her opinion the cause of all the trouble. Examination showed the truth of her statement as to the malposition of the organ. There was, however, no tenderness about ovaries or tubes, no endometritis, no leucorrhœa, no symptoms of inflammation, acute or chronic. Replacing the uterus and holding it in position with an Albert Smith pessary, I gave her a few treatments with a bipolar faradic current from a long, fine coil. I then advised her to go to friends in the country, live out doors, and enjoy the good country fare, telling her to forget her uterus and take life easy. It seems she soon became dissatisfied with this course of treatment, fearing I had not appreciated what she thought was her serious condition. She returned to

Detroit, went to one of the large public hospitals, and as I afterward learned was curetted twice, then had the ovaries removed and lastly the uterus fixed to the abdominal wall. To-day she is a bed-ridden invalid, dependent upon her friends.

Another case of a different nature was that of Miss B., twenty-six, a hysterio-epileptic. Her attacks were very violent, accompanied by tonic and clonic spasms, during which she would throw herself violently from the bed against the walls and floor of her room. She went to New York, the ovaries were removed and the report of the operation says they were studded with small cysts. Her convalescence was retarded by mild attacks of her trouble, and the operation did not benefit her in the least.

Last summer I was called in a hurry to see a patient, Mrs. C., who had taken an overdose of chloral with suicidal intent. I had once before, some two or three years previously, attended her for a brief interval, and knew that she had always been considered decidedly queer, so when she recovered sufficiently from the effects of her folly I obtained from her her intervening history. She recognized her condition, admitted she wished to die, and said she had been growing worse ever since my previous visits. Some months before, because of some local pains, etc., a prominent old-school gynecologist in Detroit had advised oöphorectomy, promising relief from her local trouble and mental also. It had been performed; she was undecided whether it had relieved the local pains or not. Certainly it had not relieved her mental condition. Soon after she went to the insane asylum at Flint. Her present condition I am unable to state.

These cases may be taken each as a sample of its class, and it is my purpose to briefly investigate to what extent the sexual system of woman may be held accountable for her nervous illnesses.

A large number of women suffer from that tedious and

distressing malady neurasthenia, or nerve strain. The nervous nature of woman is a never-ending study. More pitiful, more long-suffering than man, more cruel in anger, more relentless when jealous, feebler, an appeal to her affections turns her muscles and nerves to iron and brass, and she is able to undergo an amount of fatigue impossible for stronger men. There is another side to this picture; the finer a creation the more easily is it damaged—once upon the downward course no toboggan runs more swiftly or surely to the end. The griefs, the cares, the worries, the jealousies of life, strain and exhaust this delicate mechanism until at last there is a picture similar to the first case related in this paper. How often do we hear the story, "Doctor, I am so tired all the time, so nervous, I cannot walk far; pains in my side; such a bearing down; such a headache; my back is nearly broken in two."\* To this we may add an irritable bladder, skin dry and harsh with pigmentation in places, the complexion perhaps becoming dark and mottled. "Now let a woman with the foregoing symptoms recount them to a female friend, and she will be told that she has womb disease. Let her consult her physician and he, especially if she has backache, bearing-down feelings, an irritable bladder, and pain in the ovaries, will assert the same thing, and will diligently hunt for some uterine lesion. If one be found, no matter how trifling, he will attach to it undue importance and treat it heroically as the erring organ. If no visible or tangible disease of the sexual organs be discoverable, he will lay the blame on the invisible endometrium or the unseeable ovaries, and continue the local treatment. In any event, whatever the inlook or outlook, a local treatment more or less severe is bound to follow. Yet these very exacting symptoms may be due wholly to nerve strain, or (what is synonymous) to loss of brain control over the lower nerve centers, and not to direct or reflex action from some supposed uterine disorder."\* Sometimes in these cases an

\* Professor William Goodell.

operation acts the part of an incantation. The dread of the knife and the shock of the operation distract the mental attitude of morbid concentration, while the enforced rest in bed gives a chance to the worn-out brain to regain strength. "This leads me to think that in a large majority of operations upon trifling tears of the cervix and on the incomplete lacerations of the perineum, the good which may accrue comes less from the repair of those organs than from the mental distraction and enforced rest. Where oöphorectomy has done good in functional cases I am strongly convinced that it has been through the profound impressions upon the mind of the subject rather than upon the removal of the ovaries, and in two or three cases I have been made fully aware of this, not only in the cure of imaginary troubles, but in relief of the physical disturbance."\*

Much credit that has been claimed by operating gynecologists is really due to this mental reformation, leading the patients to exaggerate their improvement as they magnify their distress. If you will read the article of Professor J. W. White, published in the *Annals of Surgery*, vol. xiv., on the curative effects of operations *per se*, you will be able to gain some idea of how radical may be the effects upon some lesion of the body of an operation unsuccessful in accomplishing the design of the surgeon, or undertaken with some other object in view: for example, the disappearance of a uterine fibro-myoma after an exploratory incision, the disappearance of epileptoid symptoms from a mere incision of the scalp. But this kind of incantation—this surgical variety—does not always work well, as you will remember in the first case I read you.

I call to mind a patient living within a stone's throw of my office, upon whom was performed a double operation for laceration of cervix and perineum, because of nervous symptoms; to-day, two years after the operation, she is ten

\* Professor William Goodell.

times worse than before it. Her increase of symptoms dated from the very hour of the operation. The most competent gynecologists in Detroit have examined her and pronounced the operation perfect in its results; nevertheless local treatment, electricity, and social excitement had failed to relieve her present symptoms. Not until I persuaded her to travel and rest did any amelioration begin. In my experience, the mistake usually made in these cases is that of attributing to the laceration the mock uterine symptoms of nerve prostration.

Let me now call your attention to a class of cases represented by the second of the cases mentioned in the beginning of this paper, cases of hystero-epilepsy—which are not epilepsy at all, but hysteria—and epilepsy proper. “I think I may say positively that oöphorectomy has never cured a case of well-established or even incipient organic nervous disease, or has proved to be the least use except in functional disturbances that could have been helped by agencies far less dangerous.”\* We rely too much upon our diagnosis of reflex irritation or excitability, and do not consider enough the part the whole nervous system plays in the development or existence of local depraved states. “To what particular degree the ovaries enter into the production of nervous disorders is a matter of great doubt and speculation, and it is always well to assume that the disturbances, in which they are supposed to figure are of a general character, and follow a more or less profound upheaval of the functions of the cerebro-spinal and sympathetic systems, and as well to inquire whether the pelvic derangements are not more a result than a cause.

“The researches of neuro-physiologists and clinicians go far to show that neuroses of development are those in which diseased ovarian functions are quite as, if not more, common than where intrinsic disease of the organ itself is regarded. . . In the majority of cases it is certainly well

\* Allan McL. Hamilton.



to inquire whether the difficulty is not due rather to causes that have to do with general physical defects, and particularly those of the nervous system.

"It is well known that a variety of disorders which are supposed to be essentially seated in the genital organs may exist without lesions or abnormalities of the parts, and it may be, as Rosenthal says, 'hysteria is nothing but a congenital feebleness of resistance or one acquired by vasomotor centers.' "\*"

Epilepsy, omitting the form known as Jacksonian epilepsy, is a disease we may divide for convenience into three classes, dependent upon the probable pathological origin.

First. Those cases, probably cortical in origin, presenting many features of Jacksonian epilepsy. This class includes all cases of *petit mal*, and *grand mal* with anaura, psychical epilepsy, traumatic, and organic cortical disease.

Second. This class represents the phenomenon of a sudden loss of consciousness, with or without general convulsions. The attacks resemble the early symptoms of gross lesions of the pons or medulla, and can be produced by irritation of those parts; accordingly the attacks have been attributed to a discharge of nervous energy or vasomotor spasm originating in the medulla.

Third. Those in which attacks are due to peripheral irritation.

It is of course only in the third class that even the suspicion of a hope could be entertained that oöphorectomy or any operation would give relief. The diagnosis should of course be clearly made out, and all other forms of irritation carefully excluded.

It is quite possible in epileptics to have amenorrhœa, depending not on any pelvic condition, but upon spinal malnutrition or the opposite condition of menorrhagia, with perfectly healthy ovaries, the losses not depending upon any excitement *per se* of the organs of generation them-

\* Allan McL. Hamilton.

selves. Much weight has been laid upon the fact that in these cases the fits are often augmented periodically; this has been given, I think, undue prominence, as also the fact of the amenorrhœa. These patients are often exceedingly anæmic from bromides long continued and from malnutrition. In other cases the mental feebleness and weakness of will results in the loss of sexual restraint, which is so common with idiots and the epileptic insane that one-sided observers are quite apt to ascribe these manifestations to exaltation of local sensibility. The instances where the operation has been performed with good results in cases in which epilepsy existed in a quasi-hysterical form appear to have been those which have not had the benefit of systematic moral treatment.

The increase of insanity, both considerable and constant, has led to much dissatisfaction with the present modes of treatment. The better understanding of the anatomy, physiology, and pathology of the nervous system, the wonderful achievements of surgery in all parts of the body, have led to the abandonment of old and tried measures, the experimenting with many and varied means of relief, the formation of extravagant hopes. Yet we have stubborn facts to deal with. We must not be led away by any fond expectations, we must not chase any illusive Will-o'-the-wisp, but rather be governed by results as they really are, by the conclusions of men of sound judgment and ripe experience.

C. A. Kirkley, M. D., published some observations made at the Toledo Hospital for the Insane, where, in twenty-seven per cent. of the women admitted, the cause of the insanity was attributed to some disease of the reproductive system. Of 595 cases at least 230 practiced masturbation. Of these the majority were married, and some were advanced in years, and most of these practiced the habit during the climacteric period. An interesting fact was developed in the investigations, showing that sexual per-

version is almost always present in cases where religion has been given as the exciting cause of the insanity. Seventy-five cases were treated for disease of the reproductive organs with but little influence on the condition of the mind. It is only in occasional instances where a cure results, and the relation of the sexual organic diseases to that of the mind is more one of effect than cause. It is only where the general health is benefited by the treatment or operation that good results are obtained. And the improvement is only due to the gain in general health directly, and not to any relation between the disease of the sexual organs and the brain. (*Annals of Gynecology.*)

The proof has not yet appeared that irritation of the genital organs has produced any well-defined disease of the nervous system. I mention the following case by the permission of Dr. Charles S. Morley, under whose care the woman was: A Mrs. B., from being a pure, innocent girl, not knowing what sexual feeling was before her first marriage, became a confirmed pervert. No form of masturbation was unknown to her, no method of congress too debasing, and no companion too vile. These attacks were periodical—between times she felt an inexpressible horror and disgust for her shortcomings. She experienced no gratification from her indulgences, but was led on by an impulse she could not control—a periodical insanity, as it were. I assisted Dr. Morley at the operation, which was a very severe one. There was surely local cause enough to account for anything; adhesions, congestions, thickened pus tubes, etc., were all present. Everything was removed as closely as possible to the uterus. The patient recovered from the operation, and for a few months forsook her old habits. In the hospital reports the case was reported as a cure, and had this article been written earlier, might have appeared as a most remarkable result of abdominal surgery. But alas! she fell from grace, and, minus tubes and ovaries, is as bad a sinner as before. Her husband reports

that physically the operation was a complete success, and morally as complete a failure.

"To those who are familiar with the genesis of insane delusions and the conduct of insane themselves, there can be little doubt of the exaggeration and false interpretation of local hyperæsthetic disorders. The evolution of erotic delusions is a very complex process, and occurs in women whose primary derangement is of a perfectly pure and sometimes religious nature. . . . Often a period of this nature will precede erotic concepts and actions which lead the observer to look to some peripheral genital excitability as the solution of the problem. These states of primary mental disturbance resulting in sexual perversion are found in both men and women." \*

The temptation to operate is strong, and the surgeon is urged by the friends to do something because of failure of past neurological treatment and the gloomy prognosis given by former attendants. These operated cases will prove to be like the man of the parable, from whom was cast out the unclean spirits, only to return sevenfold to their swept and garnished house, and the last state is worse than the first.

The question may be raised, Supposing the results of these operations are not as favorable as we wish, should we not give these sufferers the small chance there is? We answer, No.

It must be admitted that there is in the operation of oöphorectomy considerable risk. The most successful operators the world can produce may reduce the mortality to below five per cent., but the average operator will find his mortality about fifteen per cent., some more, some less. The dangers are of course increased when the patients are suffering from a severe nervous malady.

Again, gynecological operations are more likely than any other operations to affect the mind, and the percent-

\* Allan McL. Hamilton.

age of cases of insanity following abdominal sections is as large as for any capital operation; especially is there a liability if there be a nervous taint.

Lastly we come to the psychical results of these operations and the legal complications which may follow. Though there may be no radical departures from the female type, there is undoubtedly the loss of sexual feeling, and it may be unhappy marriage relations will follow. Whether such conditions might not be considered legal ground for separation has, I think, been decided in the affirmative. Another effect noticed has been the bringing to the surface and intensifying the desires for maternity theretofore either dormant or not existing at all. A patient upon whom I operated a short time ago, removing a multilocular cyst of each ovary, has now her desire for offspring increased tenfold. Time adds to her feeling rather than decreases it.

Cases must be few indeed where any real hopes of improvement outweigh the risks of failure, positive damage, and death.

Dr. Hamilton, in his article already referred to, says: "I asked one of America's most learned and consistent specialists, 'In what proportion of cases does this operation cure nervous diseases so far as you know?' He replied, 'I never remove the ovaries for nervous disorders, as I believe the fault to lie in such cases in the nerve centers.'"

"The day is past when the gynecological surgeon, like the Indian warrior with his scalps, can boast of his prowess by the number of uteri, ovaries, and tubes hanging to his belt. The chief honor will not be in their removal, but in their salvation while yet a part of their owner's body." (Dr. O. S. Runnels, *Med. Century*.)

## A CASE OF OBSTETRICS, WITH A PECULIAR COMPLICATION.

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BYE. D. BERGEN, M. D.,  
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JUNE 21, 1893, 1.30 P. M., I was summoned in haste to see Mrs. E., age twenty-three, in confinement, primipara, who had been in labor since 7 A. M., and the pains were very severe and frequent. On arriving I learned that just after her husband left the house for my office she had a very sharp, shooting pain, and then the pains ceased to be severe and frequent and I found her resting very easy.

On examination I found the os uteri dilated about  $2\frac{1}{2}$  inches in diameter, the head in the superior strait, and a left occipito-posterior presentation, and a depression along the line of the linea alba from the umbilicus down about three inches, which seemed to me a longitudinal division of the linea alba. Having never before met a similar case, thought it advisable to have counsel, and a message was sent to Dr. Davis, who responded immediately.

Taking a bandage about five inches wide and five feet long, we placed it over the fundus of the uterus and put it around the patient, and holding the bandage tight, the depression was not perceptible; and with each uterine pain we would make contraction, which soon increased the labor pains, and at 3 P. M. I ruptured the membrane, and at 3.30 P. M. delivered an eight-pound girl. In about fifteen minutes I delivered the placenta, and with my hand over the fundus, the uterus relaxed, and a profuse hemorrhage followed and she grew very weak. I grasped the abdominal muscles and pressed the uterus over to the right iliac fossa, and had the assistant give a spoonful and

a half of ergot, and in about twenty minutes the uterus was well contracted. I had the assistant hold the abdominal muscles together, and I took absorbent cotton and made two rolls about six inches long and two inches in diameter, and placed one on either side about two inches from the depression, and applied a rubber bandage, drawing it tightly, and kept her quiet for four days. Before leaving I gave her one-half teaspoonful of ergot and left her acon. and arn. to take every hour alternately.

June 22. Temperature normal. Rest well and her kidneys acted freely. Continued acon. and arn.

June 23. Temperature  $101\frac{1}{3}$ ; rested well and had an offensive discharge. I ordered an injection of warm water,  $1\frac{1}{2}$  pint, with 5 drops of carbolic acid, and continued acon. and arn.

June 24. Temperature  $101\frac{1}{2}$ ; rested well and the odor had disappeared, but the bowels were bloated and painful. I ordered an enema of warm water,  $1\frac{1}{2}$  pint, with a tablespoonful of glycerine, and her bowels moved freely. Continued acon. and arn.

June 25. Temperature normal, and she was doing well. I examined the parts and found the depression was disappearing. I tightened the bandage, and told them that they could change her position and I would see her in one week.

July 2. I found her resting well, and the depression had disappeared, with the exception of near the umbilicus, where there was a small opening. I removed the cotton pads and put the bandage on and left it there until the end of the fourth week, after which I loosened it, and at the end of each week until the eighth; then I removed the bandage, and the patient is well and hearty.

## PUERPERAL (URÆMIC) CONVULSIONS.

BY

WILLIAM I. TYLER, M. D.,

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HAVING read with considerable interest Dr. George Logan's article on "Puerperal Convulsions" in the March JOURNAL, I am moved to report a case which occurred recently in my practice. Thursday evening, December 28, 1893, at half-past six o'clock, I was called to attend the wife of a young barber (Irish descent) who was suffering from "severe backache." When I reached the bedside I found the woman, seven months pregnant, groaning with pain, which she located in her back. She would be questioned with difficulty, owing to the distracting influences of the pain.

I made a careful examination and found the os patulous and but slightly dilated. Thought to try to stop the progress of labor if possible, so enjoined strict orders to be perfectly quiet in recumbent position, and administered ergot and sabina (Hughes).

Visited patient again at 8.30 o'clock, and found her in about the same condition as previously—still suffering greatly. Administered morphia hypodermically and went home, first making more careful inquiry regarding history.

Multipara; two living children, æt. eight and two respectively; labors uneventful. Mother had been in rather delicate health since her last child was born. Noticed about two weeks before present sickness that limbs were beginning to swell badly, but thought it was not of sufficient importance to call for medical advice.

The symptom led me to be somewhat apprehensive—



though all cases of bloating of limbs during pregnancy do not result seriously. I had not seen the case before that evening, so could do nothing for that condition.

The injection of morphia seemed to quiet the pain, so I left the house, stating that I would call again before going to bed. Called again at 10.30 and found that labor had made no progress since my previous visit, but the pains were beginning again. I left, with instructions to call me if I was needed, a nurse having been procured in the meantime. At midnight I was summoned to the bedside. Labor was progressing naturally and rapidly, the os being well dilated and vertex presenting. Labor was terminated about two o'clock, the placenta coming away entire and all right. The patient was given a drink of hot milk and tea, and after helping oil the baby (a three pounder, which died from inanition in less than a week), I saw my patient resting comfortably, good pulse and respiration, so left the house about three o'clock and went home.

At 4.30 the bell was rung violently, and the husband announced to me that his wife had just had a spasm, to "come quick."

I reached the bedside in time to see her go into a second horrible convulsion, resembling in every respect an epileptic seizure.

Chloroform was administered temporarily to relax the muscles.

After coming out of the spasm she sank into a comatose condition, with stertorous breathing.

Belladonna was given as long as she could swallow, which was only a very short time, for her strength was soon nearly completely exhausted from the frequency and severity of the spasms.

I then gave her morphia and atropia hypodermically with temporary benefit, before which, however, the uterus was thoroughly washed out with bichloride solution.

Urine almost entirely suppressed. By catheterization

only a few drops of bloody-looking substance could be obtained. The convulsions continued with more or less regularity all day, then were finally controlled by rectal injections of chloral hydrate mixed with a little milk.

The comatose state grew more and more serious. The jaw dropped, and someone had to sit by the bed and hold the jaw forward constantly to prevent her from choking to death. The face became cyanotic, and every appearance warned us of apparently approaching death.

Believing the convulsions and accompanying condition to be of uræmic origin, I used every effort to restore the urinary secretions. Applied hot fomentations to the back and loins, and gave an aqueous dilution of cantharis hypodermically. At midnight, when I used the catheter again, I was rewarded with a little urine, and the patient aroused partially and called "George" (her husband).

This gave me a glimmer of hope, and I continued the same treatment.

At six o'clock in the morning I got considerably more urine and could rouse my patient with some difficulty. She continued to improve rapidly from this time on, and could soon take her remedies and nourishment per stomach.

The woman is now strong and well. As soon as an examination could be made of the urine it was found to contain albumin, which soon disappeared, through the agency of apis and lycopodium.

One interesting feature of the case was the condition of the eyes. When she got up and began using them she found "everything double," due no doubt to the violent contraction of the ocular muscles. Gelsemium fixed them all right.

There is some difference of opinion among authorities as to the cause of puerperal convulsions. Uræmia can be laid at the door of most cases, can it not?

## THE BANDAGE AND THE DOUCHE IN OBSTETRICAL PRACTICE.

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BY

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THE object of this paper is neither to condemn nor eulogize the use of the bandage and douche, but to give the experience of the author and the inferences naturally drawn therefrom. Since the preparation of this article was begun I have found too true the words of a fellow-practitioner, who once said: "Of all the departments of medical practice, the family obstetrical furnishes the poorest field from which to gather correct data or facts of any kind." Nevertheless, after a careful examination of the records of fifty consecutive cases, I am able to produce the following in evidence: First. That the abdominal bandage upon the puerperal woman is not only useless, but in many cases a positive injury to the patient. Let us first consider its uselessness. The most important reason I have been able to obtain for the use of the bandage in normal cases of labor is from the patient herself, and is (as she puts it) "to prevent having a large stomach." Does it do this? I answer, No. If there is any influence gained at all it is to weaken the abdominal muscles so that when the bandage is removed their weak, flabby condition, caused by their artificial support, permits of relaxation to a greater or less extent, leaving the patient with a more protuberant abdomen than simple unaided Nature would have imposed upon her. In what way is the bandage found to be injurious? The snugly applied bandage does not allow of the natural expansion of the abdominal walls in breathing, but keeps a constant pressure upon the viscera, which with every

inhalation of the patient tends to drive the subinvolted uterus, unsupported by a temporary relaxation of its ligaments, down upon the sacral nerves and perineum, if she is fortunate enough to have one left, with the result of which the profession is already too familiar. I believe this to be an instance where mother Nature has provided for the emergency and if allowed to she will contract those abdominal walls as fast as the viscera are prepared for it. So much for the bandage as applied to the mother.

Second. That the band upon the newborn babe is equally useless and often injurious. Of all people upon this earth of ours I believe the infant should be the least hampered by clothing, therefore I object to the so-called band. It does no good, but prevents the child from breathing properly, interferes with the natural development of the muscles, and increases the liability to inguinal hernia. What shall we do with the stump of the cord? After it is securely tied let it alone; put no dressing upon it; simply allow it to shrivel up and drop off, which it will usually do in from three to five days. I am often asked how to prevent the umbilicus from protruding. Here again Nature has provided for the emergency. If you will remember the anatomy of the child at birth, it will occur to you that the liver is situated very nearly in the center of the upper part of the abdominal cavity, and as the child grows, shifts its position lightly to the right, causing slight traction upon the round ligament (obliterated umbilical vein), while the bladder rests high and gradually descends into the pelvic cavity as age advances, dragging with it the obliterated hypogastric arteries which are attached to its lateral surface and the urachus at the fundus, which, as you know, are both attached to the umbilicus. These two forces combine to prevent protrusion and cause retraction of the umbilicus.

I regard the douche, if properly applied, of as much value in obstetrical practice as the forceps, and I should no more

think of using it in every case of labor. It is our ally in case of sepsis, it aids us in controlling high temperature, whether caused by sepsis or otherwise, and where hemorrhage is excessive it is a friend indeed.

By the term properly applied I have reference to the temperature of the water, quantity used, and frequency of application, also that it should be rendered aseptic or antiseptic, or both. All of these must necessarily be governed by the judgment of the physician in charge. However, I believe too much cannot be said against the barbarous treatment of administering ice-water douches or packing the vagina with the ice itself, from the pernicious effects of which the system seldom recovers. I am happy to state that this custom is, as our well-meaning chief executive once said in another connection, "fast falling into innocuous desuetude." I believe this is especially true of our own school of practice, as I do not recollect a single instance within the last two or three years where a homeopathic practitioner has resorted to this expedient. For simple flushing I believe the temperature of the water used should be about the same as that of the body, 95° to 100° Fahr., or what is commonly called tepid. To check hemorrhages, from 110° to 120° Fahr., or as hot as can be borne by the patient, remembering that you cannot depend upon the partly anæsthetized patient to indicate the temperature which can be borne without injury. To render the water antiseptic I prefer carbolic acid as the most effective and the least injurious. As to the quantity and frequency, it must depend entirely upon the condition of the patient and the object you desire to accomplish.

The idea I wish to convey is that I use the douche as I do the indicated remedy, refraining from it except when Nature cries out in distress through some pathological condition, holding that Nature unhampered and at her best cannot be improved upon.

## ELECTRICITY : ITS PLACE IN GYNECOLOGY.

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BYJ. C. DAILY, M. D.,  
FORT SMITH, ARK.

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WHEN the American Institute was first organized homeopathic therapeutics was so vastly different, and its application to diseases so infinitely superior to the allopathic school, that the homeopathic profession, almost to a man, devoted its whole energy and time to the study of materia medica, and a mad search for the similimum, and we are to-day reaping, and will ever continue to enjoy, the lasting benefits of their patient study. As the Institute grew, and the number of homeopathic physicians increased, the national body gradually attracted to itself men with the surgical instinct, who, while they acknowledged the power of the homeopathic remedy, saw and appreciated its limitations. This class of men rapidly increased, and the application of antisepsis to surgery has produced such marvelous results that a large proportion of the profession has become as enthusiastic on surgery as were the early homeopathists on therapeutics. As a result the bureau of gynecology has become a camp of warring factions, one faction insisting that the similimum is all-sufficient, the other clamoring for the knife.

During the last few years a new Richmond has appeared on the field : electricity, the intelligent use of which has been made possible by scientific study and modern apparatus, has entered the arena to do battle for suffering humanity. It has been used in medicine from time immemorial ; but until recently its use was nothing more than a species of quackery, and this is especially true of its use in gynecology. It is but a short time since the mass of the profession was in the densest ignorance concerning

the most elementary facts in regard to this potent remedy. We not only failed to differentiate between the positive and the negative poles of the galvanic, and the different sized coils of the faradic, but even failed to appreciate the field for application of the different currents themselves. But thanks to the labors of Apostoli, Engelmann, Goelet, King, and others, a flood of light has poured in upon us, and these facts have become the A B C's of electric literature.

We now know that if the two poles of a galvanic battery are introduced into living tissue electrolytic decomposition takes place, and that the acids and oxygen are attracted to the positive pole, and the alkalies and the hydrogen to the negative pole. As a result the therapeutic effect of the two poles is entirely different. The positive pole is hemostatic, coagulating, and sedative; the negative pole is irritating, softening, and produces absorption. We know that in the faradic batteries there is a vast difference in the therapeutic effects of a current from a short, thick wire—the current of quantity, and the current from a long, fine wire—the current of tension; one is a current of volume, the other a current of intensity; the first produces stimulation, the second sedation. One acts on the muscles, the other on the nerves. The current of tension also acts on the vaso-motor nerves, increasing the circulation; and assists in the absorption of exudations. From these facts we can readily see the indications for the different sized coils.

When we want to produce stimulation as in subinvolution we use the current of quantity; when we want sedation we use the current of intensity. While these facts guide us unerringly to the proper current and the correct pole or coil in well-defined cases, still, we are constantly meeting cases in which the indications are not so clear cut, and in which, as in the selection of the homeopathic remedy, we must use our own judgment, not only as to poles and coils, but as to the proper milliamperage.

Our knowledge of electricity is still in the formative

stage, and much is yet to be learned ; but notwithstanding our imperfect knowledge, I believe the modern use of electricity is the greatest advancement that has been made in gynecology in the past decade. Electricity in medicine has had its rise, its fall ; but its star is in the ascendant once more ; and this time it has come to stay, for its present use is based on scientific principles. Like all great medical discoveries, it has produced its full quota of cranks, who expect to find in its use a remedy for all human ills ; but the vast majority of electro-therapeutists have no such exalted ideas of its value. They see in it a curative agent for a large number of diseases of the female generative organs, which other therapeutic remedies fail to cure, and where a just conservatism and a proper regard for the rights of the weaker sex "must bid us pause" before submitting such patients to the surgeon's knife. It cannot supplant the knife in lacerations of the pelvic floor and of the cervix uteri, in cancer of the uterus, pus tubes, or in any condition of the pelvis in which pus exists. What, then, are the diseases in which electricity is indicated ? In fibroid tumors ; uterine hyperplasia ; subinvolution ; chronic ovarian inflammation ; chronic pelvic inflammation, with exudation ; in all forms of uterine hemorrhages ; in certain forms of amenorrhœa ; in endometritis ; prolapsus and versions when due to relaxation of tissue ; in dysmenorrhea ; obscure pelvic pains ; in occlusion of the os and stenosis of the uterine canal ; in all forms of hystero-neuroses, and in disorders of menstruation, the gynecologist will find in electricity a remedy whose power for good is incalculable.

In disorders of menstruation A. Lapthorn Smith says : "I can recall case after case of amenorrhœa in stout women who have been made to menstruate ; sterile women who have been made to conceive ; of women who have suffered untold agony at their menstrual periods, and for the most time between it and the next, who have been



made to see the flow come on without the slightest pain; and as for amenorrhagia, I have never known it to fail."

I have had considerable experience with electricity in disorders of menstruation, and it agrees in the main with that of the distinguished author quoted. The control of uterine hemorrhage by electricity is one of the things in medicine that we can positively predicate. When the hemorrhage is due to subinvolution following confinement or miscarriage, or is due to relaxation of tissue from any cause, coarse wire faradism, with slow interruptions, is the remedy; but in those cases in which the menorrhagia is due to uterine hyperplasia, granular endometritis, or fibroids, positive abdominal cauterizations are indicated. The magical effect we sometimes see from this treatment is due not only to cauterization of the endometrium by the acid liberated at the positive pole, but also to the interpoler action on the vasomotor nerves, whereby the whole pelvic capillary circulation is regulated. I have recently dismissed as cured a lady who came to me a few months ago with a severe case of menorrhagia, which had lasted for months, duration of flow from ten to twelve days, and was very profuse; patient was weak, anæmic, and exhausted by prolonged flow. She was the mother of five children, born in rapid succession, and ten months previous to her first visit to me she had miscarried at the fourth month. Examination revealed an enlarged uterus, sound passing to the depth of  $4\frac{1}{2}$  inches; there was also granular endometritis. The tentative use of the dull curette brought away a mass of granulations. This was a case that would ordinarily have been treated by curetting and packing. I began treatment with bipolar, intra-uterine faradism, using current of quantity for the purpose of overcoming the subinvolution. This was followed by positive utero-abdominal cauterization every second to third day, using from 40 to 100 milliampères at each séance. The improvement was marked from the

start, and in three months patient was discharged cured, uterus measuring but three inches. The flow lasted but four days, painless, and in every way normal.

Dysmenorrhea is the *blêe noire* of womanhood. A large number of women suffer more or less pain with their periods, and a great many live in constant dread of its monthly appearance. It is not always easy to ascertain its ætiology, or to locate the cause; but whether it be neuralgic or obstructive, membranous or ovarian, it will disappear under the use of electricity like the dew before the rising sun. I am not advocating the use of electricity in every case of dysmenorrhea: many cases will promptly recover from the administration of the indicated homeopathic remedy, or by improving the general health, building up the system, and by instructing the patient as to the proper hygiene; but many cases persist in spite of all these measures, and electricity is our last and best resource.

In dysmenorrhea of purely neuralgic type bipolar vaginal and intra-uterine faradism—current of tension—gives the best results. I have cured many cases in from three to twenty treatments. When the pain is due to obstruction in the cervical canal, or at the internal os, I use negative utero-abdominal galvanization, 10 to 20 milliamperes.

In painful menstruation of ovarian or tubal origin electricity will not disappoint you. The following case will illustrate method of treatment: Miss M., aged twenty, consulted me in June, 1893, for dysmenorrhea. The pain was very severe, and generally preceded flow for from one to three days; worse in region of left ovary. The pain never disappeared entirely from the ovarian region; was aggravated by walking, standing, or dancing. I gave her dorso-abdominal galvanism at irregular intervals till September, when patient married and moved to another portion of the State. In January she returned and again placed herself under my treatment; the dysmenorrhea having been

aggravated, rather than improved, by the marriage. An examination revealed an enlarged, sensitive, and prolapsed ovary. The region of left ovary and tube was so exquisitely tender that an examination was almost impossible. I began by treating with vaginal bipolar faradism—current of tension—and continued its use till sensitiveness to pressure was relieved. I then substituted the clay ball vaginal electrode, attached to the positive pole, applied as nearly to the ovary as possible, the negative clay pad being applied to the abdomen. At first only 20 milliampères were used for five minutes; but this was gradually increased at subsequent treatments to 70 milliampères. The ovarian pain was relieved after three applications of faradism, and the January flow came on with but little pain, which lasted but a few hours. The subsequent periods have been painless. During the last month of treatment the negative pole was attached to the vaginal clay electrode, for the purpose of producing absorption. The treatment extended over a period of four months, at the end of which time patient was discharged cured. The flow was normal and painless, the inter-menstrual ovarian pain was gone, and the enlarged and tender ovary had disappeared. Can any other treatment offer as good results?

Your patience and my time will not permit me to discuss electricity in all of the diseases enumerated above; but I can truthfully say that I have never seen other than good effects from its use. When compared with the local treatment formerly in vogue—the application of carbolic acid and iodine, hot water and boro-glyceride tampons, nitrate of silver and chloride of zinc—the advancement is as great as that from the ancient mule-car to the modern electric motor.

Its use has certain obvious drawbacks: expensive apparatus, and the trouble and worry engendered in the effort to always keep it in working order; the inroads made upon the time of a busy practitioner to properly apply it, and

the difficulty of acquiring the requisite knowledge for its correct application; but these difficulties are mere bagatelles, when weighed in the balance against the health-restoring power of this mysterious agent; and no gynecologist, whose only aim is the cure of his patient, can afford to put it by without a trial.

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NOTES ON CURRENT LITERATURE.

## THE BEE LINE REPERTORY.

THE new Repertory by Dr. Stacy Jones<sup>1</sup> is a compact little volume of about two hundred pages, in flexible cover, and is evidently intended to be used as a pocketbook for instant reference when the occasion arises. It contains a great many things of value, and some homeopathy. It, however, is a curious hodge-podge, and will not make a better practitioner of anyone who uses it. It is not a repertory in the usual understanding of the term, but the various affections by name, such as Bright's disease, cancer, hay fever, rheumatism, and so on, are arranged alphabetically and various remedies recommended for the several conditions. Specific potencies varying from the tincture to the two hundredth are recommended in many cases, but why that particular potency should be valuable in a particular complaint does not seem evident. The character of the recommendations may be judged by one or two samples, as for instance: for varicose veins inject tincture of hamamelis twenty drops; for congestive headache induce nose bleed by inserting into the nostril a small roll of mustard paper and leave it *in situ* for a few minutes, when the nose bleeds and headache ceases; for a drowned person is recommended to pack the body in salt for an hour; and for seasickness chloroform one drop on sugar; for epithelioma apply cocaine twenty grains in solution on cotton; after thirty minutes the mass will fall away by slightest touch and the parts heal kindly. The book is published by the well-known house, Boericke & Tafel.

## PHYSICAL TRAINING.

THOSE who have seen Mr. Sandow perform his feats of physical endurance will be glad to read the account of his life and methods of training, which has been written by Captain G. Mercer Adams of the British Army.<sup>2</sup> Mr. Sandow is probably the most perfect type of the human form which has appeared in recent years, as he is undoubtedly the strongest of men, far exceeding Dr. Winship and all of the recent athletes. He seems to have been born with a strong predilection toward athletics, and while not phenomenally large as a child, he early became the physical master of all his companions. Having studied medicine he paid special attention to anatomy, and through this knowledge of the muscular system devised a method of physical training, which has certainly proved successful in his own case. It has the advantage over most gymnastic

<sup>1</sup> THE BEE LINE REPERTORY. By STACY JONES, M. D., Philadelphia: Boericke & Tafel, 1894.

<sup>2</sup> SANDOW ON PHYSICAL TRAINING. Compiled and edited, under Mr. Sandow's direction, by G. MERCER ADAMS, ex-captain Queen's Own Rifles, C. M., New York: J. Selwin Tait & Sons, 1894.

training in being done with very light-weight dumb-bells and rods. He recommends as an ordinary means of exercise for adults the three or five pound dumb-bell, and claims that by proper use these can be made to develop almost every muscle in the body. In fact, so complete has become his control over his own muscles that he can exercise by will power alone almost every muscle while sitting, and without any apparatus whatever. He is very greatly opposed to severe training or to the restrictions of diet which are usually imposed upon persons in training. In fact, his whole system is based on common-sense considerations, and undoubtedly if these could be carried out with the growing youth of the land we should have a very much better type of physical humanity. In the appendix is a very interesting account, by Captain Greatorix of the British Army, of the effect of this light dumb-bell exercise in improving the physique of an Eton boy who desired to apply for entrance as a cadet to the Royal Military College at Sandhurst. On the 25th of July, 1893, he was so far below the average standard as to be spoken of in a slang term as "a terrible weed," but four months afterward with only ten lessons, and with half an hour practice twice daily, during which time he was working very hard at the army entrance examination papers, and having no other physical or recreative exercise, he gained about eleven pounds in weight, three inches in chest expansion, and was as much above the average boy of his age as four months before he had been below it. To those who desire to be acquainted with a sensible method of physical training we confidently recommend Mr. Sandow's method. The work is very artistically printed, the illustrations being very superior.

# THE HOMEOPATHIC JOURNAL OF OBSTETRICS, Gynecology and Pedology.

EDITOR, GEO. W. WINTERBURN, M. D.

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## THE SURGICAL TREATMENT OF RETRO- DISPLACEMENTS OF THE UTERUS.

BY

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THERE is no surgical treatment for these diseases which has universally proved successful. The use of pessaries, tampons, frequent replacement, and electricity, all alike, as a rule, fail to cure. The half dozen surgical operations which now occupy the careful consideration of the profession to correct these malpositions yield many good results, but failure in the hands of the most expert operators occurs too frequently. Employ what intra-abdominal method you may to shorten the round ligaments during abdominal section for the ablation of diseased appendages, and you will certainly fail to afford relief in quite a large percentage of cases. When we stop to consider that many of these operations are performed on women whose vaginal supports of the uterus are torn away, and that the operator

rarely or never re-enforces these operations on the round ligaments by simultaneously restoring the torn perineum, we wonder that any of them prove successful.

Of the many operations especially introduced for the cure of these conditions but four need be mentioned: Sanger, in 1888, was the first to draw attention to fixation of the uterus to the anterior vaginal wall. He advocated that the vaginal vault be incised, the pelvic cavity opened between the uterus and bladder, and the retroposed organ stitched to the anterior vaginal wall. This operation has undergone modification by several surgeons, notably Mackenrodt, whose name it now bears, but it is yet attended by many failures.

Vaginal fixation of the retroflexed uterus by Shucking's method is not only dangerous, but it is a blind operation, difficult to execute, and too often results in total failure. First, the silk ligature of such great size acts as a seton in certain cases; in others the bladder is accidentally perforated. In many cases, which at first appear to be successful, the uterus finally relapses into its former position, and the operation is worse than useless.

Alexander's operation was invented to correct prolapsus, retroversion, and retroflexion. It necessitates that colpo-perineorrhaphy be performed to re-enforce it and guard against relapse. This operation is not without serious objections. Surgeons who are not accustomed to this form of procedure experience great difficulty at first, as they cannot readily find the ligaments. Then when they do find them it is occasionally difficult to draw them out on account of adhesions, and frequently the ligaments are broken off on one or both sides. My experience goes to show that in nulliparæ the ligaments are always so small that they are entirely unfit to hold the uterus; therefore the operation ought not to be attempted at all on these patients. Again, where the ligaments are of proper size, properly sutured, and the patient properly treated after-

ward, the uterus very often relapses into its faulty position. This is probably because the ligaments give way from their new attachments, or else stretch out. In either case the woman may be left as bad or worse than before the operation.

Ventrofixation has been employed as a means of cure, and so far it is the most reliable treatment. It enables the operator to examine the pelvic contents, and if the ovaries and tubes are diseased one or both may be removed. This leaves *in situ* a uterus which may cause pain by the dragging upon the adhesions, or break loose from its moorings, and cause many of the old symptoms.

To prevent the return of the displacement surgeons have applied pessaries, and practiced colpoperineorrhaphy and anterior colporrhaphy. Sometimes all the annoyances and added risks of these minor operations are borne, and an utterly useless organ retained, which may not only keep up the old condition, but invite malignant disease.

It is not my intention to condemn these operations. I have performed all of them many times, except Mackenrodt's and Shucking's, with fully the average percentage of success. My purpose, then, in the brief review of these operations is to draw attention to what is believed to be, by a few surgeons, a better way in certain carefully selected cases.

I refer to displacements accompanied by chronic invalidism. In many of these we find chronic, non-specific metritis, endometritis, simple and tubercular salpingitis, ruptured perineum and lacerated cervix, together with gonorrheal endometritis, and pyo-salpinx. In gonorrheal endometritis, if we would cure our patient, it becomes necessary first to curette the uterus, then to do abdominal section for the removal of the degenerated tubes and ovaries. Of course we do not amputate appendages without careful discrimination as to the condition of the parts, and we always aim to save them, provided there is reason



to believe that their functional activity is not destroyed. Where tubes alone are diseased—and this is rare—it is better to amputate them and leave the ovaries behind, unless there is uterine dysmenorrhea which cannot be relieved; then, of course, it is safer to remove all ovarian tissue. If both ovaries are removed the patient is not only made sterile, but an organ liable to produce dangerous disease remains in the pelvis.

Unless the round ligaments are shortened to prevent it, which is not always practicable, the uterus will relapse into its former position, keep up a painful train of symptoms, and annoy the operator for many months after one would have supposed that atrophy of the organ, which follows such operations, would have relieved the condition. Then there is left behind the lacerated cervix, which may not only remain sensitive and give rise to many nervous symptoms, but finally invite that loathsome disease carcinoma uteri.

If one tube and ovary are left in a sound condition it is often necessary to do trachelorrhaphy and perineorrhaphy before the patient is cured. Now where these diseases of the endometrium, tubes, and ovaries are the result of gonorrhea it is extremely rare to find a patient where one ovary and tube are sufficiently sound to permit of ovulation and fecundation. Even if an attempt is made to save these parts in case of specific disease, we often find, to the discomfort of the patient and our own embarrassment, that she is not cured.

Even where these parts are removed by the application of a ligature close to the horn of the uterus gonococci will linger in the uterine portion of the tube and cavity of the uterus, and keep up a troublesome discharge, which will not only prolong the invalidism, but propagate gonorrhea. In fact, not infrequently the woman suffers as great pain from the thickened and enlarged uterine portion of the tubes as she did before the operation was performed. To avoid this

difficulty we have amputated the tubes by V-shaped incisions in the horns of the uterus, but even this form of treatment does not cure gonorrheal cases.

It has been my fortune, or misfortune, to have had several patients on whom I performed unsuccessful abdominal sections for infectious disease of the tubes. They made my life miserable at times for a year or two. Finally, as a last resort, vaginal hysterectomy was performed. When the fingers entered the peritoneal cavity the thickened fundus and swollen stumps which had been the cause of their suffering were easily discovered and removed with the entire uterus. I have found similar cases in the practice of other surgeons, and prompt recovery followed hysterectomy.

Now in cases not only like these, but in displacements associated with non-specific, tubular, ovarian or uterine diseases accompanied by sterility, would it not be more rational and less dangerous to perform vaginal hysterectomy, with proper removal of the appendages, and cure the patient with a single operation, than to subject her to the dangers of curettement, perineorrhaphy, trachelorrhaphy, and abdominal section? The removal of the uterus would place her in shape to get well in three weeks, while the latter would require eight or ten, and in some cases fail altogether.

Vaginal hysterectomy in the hands of experienced operators is no more dangerous than ovariectomy, and in some cases by removal of the uterus one capital and three minor operations are made unnecessary. The surgeon has an excellent opportunity to inspect the parts and remove only so much as is necessary. It seems unwise to sacrifice all ovarian tissue. If possible it is better to leave one or both ovaries, even if the tubes are hopelessly diseased and removed. If this cannot be done, leave a sufficient amount of ovarian structure to prevent atrophy, chronic vaginitis, and pruritis of the vulva. These diseases, fortunately,

occur but very rarely, even when all ovarian tissue is removed.

It is commonly believed that extirpation of the uterus and retention of the ovaries in women below fifty is unwise, as ovulation leads to unpleasant and painful conditions. This I do not believe is well founded, as patients flesh up, appear healthful, and in fact express themselves as stronger and happier than ever before.

About seven years ago I performed hysterectomy for two conditions only, carcinoma uteri and myo-fibroma. A little later procidentia uteri\* was added to the list. Now, and for two years past, I have removed the uterus many times where the tubes and ovaries were so diseased that their ablation became necessary. With the increased ease and safety of hysterectomy, I am convinced that it is not only better to remove the hopelessly diseased appendages, but the unhealthy and retroposed uterus as well. This has proven so satisfactory that I find the number of cases for ventrofixation and other operations to hold the uterus in place have not increased, while extirpation of the organ and its appendages, when necessary, is more frequently performed than formerly.

Since October 1, 1893, up to the present time, June 1, 1894, a period of eight months, I have removed the uterus for all causes thirty-four times. In every instance the patients have recovered without any considerable fever or bad symptoms, except that in one case phlebitis developed, which kept her in bed ten days longer than usual. I have sought to leave behind healthy ovaries where this was possible, and in cases where the substance of the organs was degenerated I have invariably endeavored to leave a sufficient amount of ovarian tissue intact to insure the future existence of a normal vagina and external genitalia.

\* This operation, however, should not be performed until the woman is clearly made to understand that in a certain proportion of cases it becomes necessary to do a plastic operation on the vagina to finish the cure.

I am so thoroughly convinced that we will get better results by making primary vaginal hysterectomies in these cases, provided proper care is observed in their selection, that I offer no excuse for taking this radical ground, although I expect to be sharply criticised. The paper is now before you, and I shall cheerfully take the consequences, as I believe that there can be no question but that hysterectomy is more scientific and yields better results, in well-selected cases, than any of the other operations.

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## UTERINE EXTIRPATION.

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BY

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SAUTER of Constance successfully performed the first vaginal hysterectomy for cancer, seventy-two years ago. Recamier came second, seven years later, curing his first case. But these initial efforts were succeeded by such reverses that for fifty years the operation was disfavored and practically abandoned. About twenty years ago Freund and Czerny precipitated the discussion anew, advocating removal by the abdominal method; but the statistics were so overwhelmingly discouraging that this also became a thing of the past.

It is within the present decade that Schroeder and Martin gave impetus to the revival which may be considered the most remarkable in surgical history. Having the benefits of antiseptics, that became feasible and adoptable which before was beyond the range of advisability. Since that time professional experiences the world over have rapidly ripened the technique of this procedure, until to-day no major operation of surgery can promise greater immunity.

from danger than vaginal hysterectomy. Even that surgical terror, the operation of Freund, has disappeared as a horrible dream, and uterine extirpation by cœliotomy has become as safe as removal of simple ovarian cyst.

Statistics of proudest character have been made by many different operators, each contending with the other in his claims for the superiority of the clamp method or the ligature method, until within the last year it has been made as clear as noonday that both are cumbrous and superfluous—a veritable incubus in either case upon the ideal technique. When the anatomical fact was realized by our Chicago confrère that the non-gravid uterus is surrounded by the blood vessels as is the wine-bottle by its wicker basket; that no large vessels enter it, but that its nutrition is kept up by capillaries and the smallest of arterial twigs, the last step was taken and the goal was reached.

If it is possible to avoid the incision of arteries; to avoid the putting of a woman to bed with from one to five pounds of steel clamps in her vagina crushing and necrosing everything within their jaws and near them; to avoid the long delay incident to the application of large ligatures and the pinching and strangulation of tissues thus involved—I say, if it is possible to avoid all these it is surgical to do so, and the demand is imperative that it shall be done.

It is now certain that the invention and manufacture of broad-ligament clamps will cease, and that those already upon the market will disappear or gravitate to museums to tell of the road along which hysterectomy has traveled. Henceforth, if torsion fails, the single spurting twig will be tied, as surgical sense has always dictated, but there will be no general amassing of tissues in the stricture of common ligatures—no bundling together of nerve ends in ugly cicatrices to harass the patient the rest of the way; and fistula of ureter resultant from clamp slough will not again be left as a greater burden than the original embarrassment. With the field of operation easily accessible, the simplest acces-

sory in the management of a bleeding vessel will be employed, and all mechanical interventions calling for the wholesale inclusion of both the necessary and the unnecessary will go in and out no more forever.

But my task in this paper has other object than the portrayal of the best technique in uterine extirpation. The comparative ease and safety with which this is now done suggests another question which must have early settlement. What is the legitimate scope of the operation; under what conditions is uterine extirpation admissible? This is the most momentous question that can confront the surgeon, and should have the clearest and most explicit definition, inasmuch as vast interests are involved.

The question that must take precedence of every other in this discussion is the integrity of the woman's life. Is the malady complained of inimical to her very existence? If not interfered with will it lead to certain fatality? As in embarrassed gestation and dystocia the life of the mother outweighs every other consideration, so here jeopardy to the life of the patient becomes the paramount question. The saving of imperiled life is always the manifest duty. In all such cases the indications are unmistakable. In this category belong primarily all the phases of malignant degeneration about the treatment of which there are no two valid opinions.

The discussion takes wider range, however, when we come to consider the non-malignant conditions. Here it is that differences of opinion are at present legitimate and are like to continue till the lines of demarcation shall have been more clearly drawn. It is under this head that abuses are apt to creep in and incalculable mischief be done.

In the first place, questions of morality may be involved, and these may be as much greater than single infanticide as the woman's procreative ability can make them. It may not be the destruction of a fetus in actual growth, to be

sure, but the ablation of an organ which may be capable of bringing forth not one but many human lives. Uterine extirpation, in any event, is the destruction of the mold that is set for the reproduction of our kind; and none but the most imperative and emphatic reasons will justify its employment.

The great question to settle in every case is: Can this uterus ever again be made available as a childbearer? The affirmative to this question must invariably be the negative to hysterectomy. Fortunately for us, this is put into comparatively narrow boundaries by the limitations of age, inasmuch as the majority of those applying for help have reached or passed the menopause. With the most of them it is a question merely of health—betterment without regard to offspring.

Until very recently the only admissible cause for extirpation was malignant degeneration, and even then it was weighed in the balance with hysterectomy or some other form of treatment. But all this has now reached final settlement. It is no longer a question in the treatment of cancer, of escharotics, of section of the uterus, low or high, or of any other *régime* of expectancy in whole or in part. The removal of the entire organ with its appendages is demanded in every case of proven or strongly probable cancer. There can be no middle ground upon this question. It is here that the microscope comes in too late to be of service. Many a valuable life has been sacrificed because the microscope or the microscopist has been unable to detect the characteristic cell during the day of possible salvation.

I have reached the point where I invariably settle this question objectively, and without regard to the often-too-late histological proof. In all cases of long-continued post-climacteric hemorrhage with recurrent vegetation of the endometrium, with or without enlargement, induration, or offensive discharge, the decree of ablation goes forth. If

there, should be evidences of a bad cachexia with abnormal growth or other concomitants leading to a serious question of infiltration, or if there should be persistent vegetation upon the cervix, or a rodent and progressive ulceration, the fiat is the same: the patient in every such case should have the benefit of the doubt rather than the possession of such defective and dangerous organs.

A disease that is essentially local, that begins as an isolated growth and progresses by proliferation into neighboring parts, can be cured only by operation. "No surgeon in his senses," says Playfair, "would remove part of a cancerous organ if he could remove the whole of it without more danger." The time to use the knife in cancer is while the disease is still local and before widespread infiltration has begun.

The rule is settled also in procidentia after the climacteric. For this most troublesome condition there is no treatment comparable to extirpation with union and the consequent shortening of the broad ligaments. In very pronounced cases colporrhaphy, or complete closure of the superior portion of the vagina, should be made at the same sitting. Ventrofixation and plastic operations upon the vagina cannot serve us here with equal satisfaction. Many cases of retroflexion past middle life must look to hysterectomy rather than to the operation of Alexander.

In all cases of fibroid tumors of the uterus requiring ablation of the major part of the organ, or of pelvic inflammation of long standing with hopeless degenerations of adjacent tissue, or of irreducible inversion of uterus, extirpation may find indisputable employment. Extirpation is further advisable in all cases where removal of the ovaries is called for. If the ovaries and tubes are doomed the uterus should be also. For it is certain that while life invariably proceeds from root to branch defective nutrition does likewise, and that diseased appendages are an unmistakable indication of a sick uterus. Close analysis in every



case will establish a degenerate endometrium or some form of organic embarrassment. There will be found a thorn in the uterine flesh of some kind which, remaining after the appendages have made exit, will be sure to give expression somewhere to some form of malady. It is in such case but a useless stump without further excuse for being, and is only too frequently a source of discomfort, invalidism, and death.

Vaginal hysterectomy, including tubes and ovaries, has now become so easy of performance and so devoid of danger, so free from shock and attended with so little post-operative suffering, that it is destined to supersede suprapubic removal in all possible cases. Entrance to the peritoneal cavity by cœliotomy involves greater shock, greater danger of sepsis, more excruciating suffering, and more prolonged convalescence than does the measure under consideration, and has the added objections of possible ventral hernia and cicatricial disfigurement. But each method has its advantages and sphere of employment—its range of action. For reasons just enumerated removal by way of the vagina will henceforth find larger employment, supplanting laparotomy in very large degree. The thing essential in every case is to go to the root of the matter; to be careful not to lop off the branches of the upas tree merely and leave the disease-producer still at its post; so that the patient with hope long deferred may not have to drag on to her certain doom of unmitigated suffering. The uterus, going on with its septicity, with its chronic suppurative conditions, or with its cicatricial nerve pinchings, may still be the agent of mischief as at first, and will be sure to voice its complaint in some way.

But lest I may be misunderstood upon this subject, I want to say in most emphatic manner that the removal here advised should never be made while there is the shadow of possibility of saving the generative organs for useful life. If medication, electricity, massage, divulsion,

curettage, packing of uterus, trachelorrhaphy, exploratory incision, and even the removal of the annexa of one side in suitable cases, have not proven efficacious in the long course of conservative endeavor, then only may this procedure be legitimate. It should be in non-malignant conditions the *dernier ressort*, the thing to be employed only after the exhaustion of all other means of betterment. While it must be the first in malignancy, it must be the last in non-malignancy.

We are still in the infancy of our investigations, to be sure, but this seems so clear as to demand universal acceptance.

Questions may arise in the individual case—questions of expediency, if you please—which may have such bearing as to take precedence and prove the determining factor. The thought of being “unsexed,” as it is termed, is an insuperable barrier in some minds. Closely analogous to this, and a part of it, is the question of the influence of the ablation upon the aphrodisiac or erotic capabilities of the married woman. While these are minor questions compared to the fact of general health restoration and regained life efficiency, they demand recognition and sincere deliberation.

The repugnancy of the thought of so-called “mutilation” is dependent upon the belief that the womanly instinct and characteristics will be to a great extent transformed, or banished; that change of voice, growth of beard, and other masculine traits may be looked for; that all the finer qualities of feminine attraction will disappear. Especially is this anticipated if the uterus, rather than the ovaries, is the part in question, because of the belief that womanhood centers in the uterus. But all this is false teaching and productive of mischief. The changes that were expected as an unmistakable stamp upon the woman with extirpated genital organs have entirely failed to make themselves manifest in any reprehensible sense. One would fail utterly if he should attempt to single out these “mutilated”

people from the social mass by any such standard, inasmuch as beauty of form and feature has not suffered by the change. It will always prove helpful to be set right in this matter. The anatomical necessity of perfect womanhood is possession of the ovaries. These being gone or hopelessly diseased, contention for the retention of the uterus is baseless and worthless.

While professional opinion is somewhat at variance touching the influence of ovarian ablation upon copulative zest—based upon testimony of patients—I think it is untenable to hold that the sexual desires and enjoyments of women after ovarian and uterine extirpation are unimpaired, or in any sense equal to normal expression. Great diversity exists among women touching this matter, even among those who consider themselves in good health; some exhibiting normal desire and participation in the sexual act, while others are negative or purely indifferent thereto. When we consider that many are so abnormal in this respect while suffering from ovarian or uterine disease as to loathe and abhor embrace, it is not to be wondered at that the same women after ablation of ovaries or uterus, one or both, should experience a sexual calm unknown to them before, and enter into life experiences which are so remarkable as to be accounted by them even as average marital experiences. But while it is not possible to have full expression of function when a part of the organism is removed, it is still true that the expression possible when the diseased part is gone is so much more desirable than the morbid state calling for remedy as to be not only tolerable, but greatly to be desired. All this, however, is merely incidental, the greater question of necessity having precedence in the determination. No one would be moved to, or deterred from, uterine extirpation by such arguments alone.

## GYNECOLOGIC PROPHYLAXIS.

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BY

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WE are living to-day in an age of invention and prevention. While our electricians and inventors of different types are toiling night and day searching out further means of harnessing up the forces of nature and making them subservient to man's will, the medical world is no less busy with preventive problems of disease. Physicians are every day realizing more and more fully the truth of the familiar old adage, "An ounce of prevention is better than a pound of cure," and never was the materies morbi of disease so earnestly sought for as now. Never was a thorough knowledge of the laws of hygiene and sanitary science considered so essential as at the present time, and through the medium of the press this knowledge is becoming rapidly disseminated among the laity, so that scourges and epidemics are not so commonly looked upon as direct visitations of God's wrath, but rather as the result of ignorance, filth, or willful carelessness on the part of humanity.

The whole medical and civilized world is keenly alive to the prophylactic problems of such dread diseases as small-pox, scarlatina, diphtheria, cholera, etc., and the general death rate has been greatly lessened since measures have been taken to prevent the spread of such diseases. But what is being done to check the progress of that class of disorders which numbers more victims than any other one disease in this fair land of ours, and which dooms so many to not only days and weeks, but months and years, of miserable existence, the ultimate effect of which does not

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die with the sufferer, but casts its enervating shadow over a whole nation?

Gynecology, that child of the present generation, fathered by such giant intellects as Sims, Tait, and Emmet, has done much, very much, to relieve or cure conditions which twenty-five years ago were considered beyond the reach of human help. But what has been, or is being, done to prevent our sisters and daughters of to-day from becoming the diseased and suffering women of to-morrow? American women of the present generation are said to be more prone to diseases of their own sex than the women of any other nation. Whether this be true or not is a question, but every physician must have observed with alarm the remarkable tendency toward chronic pelvic suffering among the maturing girls and young women of the present day. Our grandmothers are held up to us as types of physical excellence, their great-granddaughters as illustrations of physical degeneracy.

We as physicians are being constantly asked to explain the cause of this too evident truism, and as it is our particular work in life to reduce disease and suffering to the minimum, it is our duty—not only for the sake of the present, but for future generations—to labor as industriously to fathom obscure and general causes as we are now working to overcome results. Not until we have arrived at an intelligent idea of causative factors can we hope to prevent deleterious effects; hence, as a necessary first step to gynecologic prophylaxis, we must investigate gynecologic ætiology.

Humanity to-day is the twin product of heredity and environment, and while mankind cannot escape predisposition to disease by choosing healthy ancestors, yet intelligent care as to environment will do much toward establishing that predisposition to health which is a more potent prophylactic than any drug which science has yet discovered.

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The exciting causes of pelvic diseases among the unmarried are probably no more numerous to-day than in the past, but the greater number of predisposing causes need to be illumined by the great searchlight of truth before we can hope to establish that love of physical morality which is the stepping stone to health and strength. To our social customs and modern methods of education are due many of the ills which gynecologists are laboring to overcome. Our schools and colleges of to-day are intellectual hotbeds forcing the young into premature bloom, and the spirit of the times seems to be to convert physical children into intellectual giants. As a result of this mental feast and muscular famine we find that "at puberty the nervous forces are diverted from their proper channels, and the reproductive mechanism, which is rapidly developing at this period, suffers from malnutrition in consequence of this perverted nerve force, and a well-developed body is sacrificed to a prematurely developed mind." By this I would not be misunderstood as opposing higher education for women. Far from it. But I do protest against the present educational system, which encourages unnecessary cramming and crowding of school work and accomplishments during the three or four years coincident with the establishment of the menstrual habit.

Not only the schools, but social duties and the thralldom of dress, begin to increase their demands upon the time and strength of the maturing girl during those years when proper physical development makes or mars her possibilities for future health and happiness. Dr. E. H. Clarke well says: "If excessive labor, either mental or physical, is imposed on children, male or female, their development will in some way be checked. If the schoolmaster overworks the brain of his pupil he diverts force to the brain which is needed elsewhere. The results are monstrous brains and puny bodies, abnormally active cerebration and abnormally

weak digestion, flowing thoughts and constipated bowels, lofty aspirations and neuralgic sensations."

Woman's ignorance of nature's laws governing her organization is another great cause of diseases peculiar to her sex. "There are fashions in thought as well as fashions in dress," and it has long been the fashion for parents to consider as immodest or indelicate any explanatory allusion to that function which "cradles the race." This is not only a foolish but a criminal delicacy which permits parents to allow their daughters to bloom into womanhood, and even assume the responsibilities of wifehood, without any intelligent idea of that part of their organization which "they hold in trust for the future of the race."

"We must keep our children innocent as long as possible," is the popular cry, but *ignorance is not always innocence*, and the growing girl too often gains perverted ideas of a sacred truth from impure associates, or by chance is left so entirely ignorant of the divine laws governing her being as to make the inception of the menstrual habit one of the most, if not *the* most, dangerous period of her life. "If I had only known!" is the cry of many a hopeless invalid, and to this utter lack of intelligence as to the structure and functions of the human body are due many of the reckless habits and customs which modern civilization permits. Of these the unphysiological dress worn by women for generations is one of the most potent causes which has helped bring about the physical degeneracy of women. During the past few years much progress has been made by the intelligent few toward solving this vexed dress question; but not until the masses are educated to understand why constricted waists, hampered lungs, heavy unsupported skirts, and high-heeled shoes are productive of pelvic congestion will there be a willingness on the part of the great majority to adopt a more rational mode of dress.

To our modern system of mental cramming and unhygienic dressing is largely due the universal lack of proper

physical exercise, which is another great cause of ill health among women. While the present popularity of tennis, bicycle riding, and physical culture is a step in the right direction, unless such exercise can be taken in a dress free from corsets, constricting bands, and heavy hanging skirts the results are more apt to be harmful than helpful. However, these popular forms of exercise are not within the reach of all, but what the American girl and woman really need *is* within the reach of rich and poor alike. It is hard to improve on God's original plan for the well-being of his creatures, and so we cannot hope to find a better or more healthful mode of exercise than regular out-of-door walking. Not only is walking important as a means of increasing general muscular and circulatory activity, which means increased metabolism and a consequent feeling of well-being and vigor, but it is an important adjunct in overcoming localized congestions.

The *psaos magnus* is one of the muscles which assist in the movements of progression. Now as this muscle lies in close relation to the inferior vena cava on the right, to the aorta on the left, and to the common iliac arteries on both sides, we can readily understand why the frequent alternate contraction and relaxation of this muscle improve or prevent a sluggish pelvic circulation. If from early youth to middle age American women accustomed themselves to a daily walk of from one to five miles there would be little need of tonics or cosmetics, and far less need of gynecologists. Our English sisters, with their fine physiques and ruddy skins, could teach us a valuable lesson on this subject, were we but willing to learn.

It is a well-known fact that sedentary habits among men lead to constipation and hemorrhoids. Is it any wonder that the usual sedentary life among women is productive not only of constipation, but uterine and ovarian congestion with their chain of sequelæ? Place man in the same strait-jacket environments of clothing, custom, and occu-



pation for one generation that women have occupied for many generations, and there would be a corresponding decrease in physical vigor and manhood.

Bodily posture in sitting, standing, and walking also bears an important relation to the physical well-being of the maturing girl. "Too often the pelvis is tilted upward and the body forward, by which the erect position is lost and the weight of the intestines allowed to come directly upon the pelvic organs," thus inducing and maintaining a chronic congestion of the parts from the very inception of menstrual life. If we as physicians recognize these predisposing factors in the chronic ailments of maturing girls and unmarried women, then the next great step in the advance of gynecology must be along the line of prophylaxis, and the time is ripe for the physician to put on the whole armor of healing and go forth to teach that the diseases of women are *not a necessary* sequence of sex, but are largely preventable by proper mental and physical habits of life. Especially should every *general* practitioner realize this truth and feel the responsibility of his position as medical caretaker of families from the beginning to the end of many an earthly existence. The time is at hand when a physician must be a teacher as well as a dispenser of drugs, a conscientious counselor in health as well as in sickness; for how shall the people know unless they are taught, and who can teach them without knowledge, and who is there with the knowledge and authority of physicians on all matters pertaining to the public health?

What, then, is the duty of every physician in this matter? Plainly to teach woman to reverence her own body, and to care for it in an intelligent way. As physicians we should not feel that we have discharged our whole duty when we have made a diagnosis and prescribed the indicated remedy in a given case. Neither have we done our whole duty when we make local application to cervix or endometrium, advise the regulation hot douche, and send the patient

away without one word of investigation or caution against her mode of dressing or habits of living, which too often lie at the bottom of the whole mischief. If we would be promoters of health as well as healers of disease, we should teach parents and patients :

1. That it is foolish and dangerous, both physically and morally, to allow a girl to pass the age of twelve without a proper knowledge of the menstrual function.

2. That for a period of at least three years following puberty there should be a minimum amount of mental and physical exercise during each menstrual period, in order that the habit may become established regularly and painlessly.

3. That want of air and exercise is deteriorating to the blood and debilitating to the great nervous and muscular systems.

4. That want of sleep, incident to excessive study or social demands, is always injurious to the maturing girl.

5. That corsets and unsupported skirts are relics of the Inquisition and a form of needless cruelty to animals.

6. That a liberal physical education is quite as necessary for girls as for boys, and that it should go hand in hand with the mental training of both sexes.

7. That if a part of the time spent in other ologies was devoted to a proper study of anatomy and physiology, we might evolve into a race with physiques strong enough to make use of our knowledge after acquiring it.

"Am I my brother's keeper?" comes ringing down the ages and sounds in every ear that has the interest of mankind at heart. May it continue ringing until the voice of every physician is raised against all erroneous habits of living—among *both men and women*—which threaten to make us a nation of invalids.

## MOVABLE KIDNEY IN WOMAN.

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BY

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THIS paper is not intended to be a systematic and exhaustive treatise on the subject of movable kidney. It is proposed to discuss briefly three points with reference to the relations of this condition to woman: 1st, Frequency; 2d, Symptoms; and 3d, Treatment.

I. *Frequency*.—All observers are agreed that movable kidney is far more frequent in women than in men. I have met with but one case among male patients; this was clearly due to traumatism, but was unrecognized by physicians for years. Among women such observers as Lindner, Edebohls, and Kellogg have recorded a movable kidney out of every five or six of their gynecological cases. To say, however, that this proportion holds good throughout would, in my judgment, be a gross exaggeration. These statistics are compiled from hospital and sanitarium cases, where we are apt to find the worst class of patients. One would therefore expect to find movable kidney far more frequently among hospital patients than in the ordinary run of private or general practice. To say, then, that one woman out of every five or six has a movable kidney must be considered far beyond the facts. Nevertheless, it occurs with sufficient frequency to make it incumbent upon every gynecologist to bear the possibility in mind and to make it a rule to give every gynecological patient a thorough abdominal examination. It is true that in past discussions upon this subject other authorities have made the claim that movable or floating kidney is practically a myth and cannot be found in the dead-house. Such observers must

surely be blind, because they *will* not see. A movable kidney is, as a rule, easily diagnosed. The sufferers are usually thin, making it an easy task to outline and grasp the misplaced organ. The frequent occurrence of movable kidney in woman we may, then, consider a well-established fact, and makes the subject one of special interest to the gynecologist.

A peculiarity equally as well marked as the difference between man and woman is its relative frequency with reference to the right and left sides. It is very much more common on the right side. Out of 22 cases reported by Edebohls 20 had movable right kidney; the remaining 2 had both organs movable. The most probable explanation of this fact is the position of the right kidney under the heavy liver. Another interesting point as regards frequency is the occurrence in single and married women. The general impression seems to be that it is far more common in married women, presumably because the overstretching and relaxation incident to childbearing are supposed to be a common cause of the dislocation. However, in Edebohls' list, for instance, we find a surprising proportion in favor of single women. Out of the 22 cases already referred to 15 were single and only 7 married. There must be other causes at work, then, prominent among which are, in my mind, faulty posture in sitting and standing, faulty and constricting dress, and debilitating sickness, leading to emaciation, with marked loss of the perirenal fat.

II. *Symptoms*.—Coming now to consider the train of symptoms to which movable kidney may give rise, we find a second important reason why the gynecologist should know all about it. Many, in fact the majority, of the symptoms which diseases of the female generative organs exhibit are reflex rather than local in character. Precisely so with movable kidney; and what is more, the same nerve wires are tapped by the one as the other, so that it is the easiest thing in the world to attribute the symptoms to the wrong

source. In a recent very marked case of movable kidney under my care a local gynecologist persisted in ignoring the kidney and insisted upon attaching blame to a perfectly normal uterus and ovaries. On account of her extreme emaciation it was possible to make a completely satisfactory examination of all the pelvic organs, and I am positive that in this case the distressing nervous and digestive symptoms were due to the dislocated kidney.

I would place first in prominence the general nervous disturbances. These are frequently of a hysterical character: the patient becomes very much depressed and melancholy; she is inclined to be irritable; and there are many imaginary pains and aches.

Closely connected with this general nervousness and just as frequent are digestive disturbances. Here we have a condition of flatulent indigestion, obstinate constipation, with, in many cases, dilatation and prolapsus of the stomach, and perhaps prolapse even of all the abdominal organs. This combination of neurasthenic symptoms with gastro-intestinal disturbances, called by Glenard "enteroptosis," is very characteristic of movable kidney. Wherever such a combination of symptoms is exhibited by a woman we should never put the sole blame upon the generative organs until movable kidney has been excluded. It may be remarked here that after the condition is relieved, whether surgically or otherwise, the digestive disturbances improve more rapidly than the nervous troubles; indeed, the latter hang on sometimes with annoying presistency.

When a movable kidney creates any disturbance there is usually pain somewhere. Sometimes it is in the region of the organ itself. More often it is along and under the free border of the ribs; Edebohls says usually along the left margin. In my case, before mentioned, the symptom of all others from which she desired relief was an intense burning pain under the free border of the right ribs. In this case there was also a recurrent painful swelling in the

ileo-cæcal region. It was only after repeated examination and observation that recurrent appendicitis could be excluded. It was no doubt due to accumulation of intestinal fluids and gases. Cardiac palpitation and inability to lie or sleep on the left side are also marked symptoms in these cases. Many minor symptoms not necessary to detail may develop.

One significant fact about the symptoms is their aggravation during menstruation and the first months of gestation, and then almost entire relief during the latter part of pregnancy. This can be explained upon physiological and mechanical principles. During menstruation and early pregnancy the pelvic organs are congested, heavy, and prolapsed. Thus, by direct dragging upon the prolapsed kidney and other abdominal organs, the already existing irritation of the sympathetic nervous system is greatly increased. But later the enlarged uterus rises and acts as a support to the misplaced kidney and other organs as well, holding them in place and giving great relief. Edebohls states that in a young woman a large ovarian cyst performed a similar service.

One word as to the cause of the symptoms. Most authorities attribute them to pressure; the dilatation of the stomach, so common, is said to be caused by pressure upon the duodenum. I much prefer Edebohls' theory, which, I think, he well substantiates, viz., that the symptoms are caused by pressure upon or irritation of the great solar plexus of the sympathetic nervous system. Here we find the key to the mischief that can be produced by a floating kidney; and as it is along the same sympathetic paths that complaints from the generative organs and the lower orifices travel, it need not be wondered at that we are liable to make "confusion worse confounded" unless we trace each to its proper source.

III. *Treatment.*—By way of passing, it may be well to remark that the poorest way to examine a patient for float-

ing kidney is in the reclining posture. It is usually in that position that the sufferer is most comfortable, for then the kidney falls back into its place. It is also quite difficult to grasp the kidney in the loin if there be any considerable deposit of adipose. Resonance or percussion in the loin counts for little. But when the patient sits upon the edge of a table, leaning slightly forward, legs hanging down, or, better yet, if she stand, leaning forward with stooped shoulders, the kidney will then be strongly displaced, and can easily be felt and outlined, as it presses closely against the abdominal wall.

What shall be the treatment of movable kidney? Medical therapeutics offers us but little help. Of course we must remember that not every movable kidney causes trouble or needs attention. Indeed, many a movable kidney has been diagnosed by mere accident. Then again, another but very small class of patients can get sufficient relief by a bandage or padded belt. Edebohls claims the best results from the use of a snugly fitting corset. Other authorities are inclined to blame the corset for a large majority of the cases of floating kidney. I am inclined to the belief that the corset can and does cause a displacement of the liver and kidneys and should not expect any help from it; nor does Edebohls take any satisfaction in external appliances.

The great number of cases which really demand and urgently need our help must be treated in one of two ways—either by surgical fixation of the kidney or by the method so stoutly championed by Kellogg, viz., massage, especially the Swedish method of gymnastics, hydrotherapy, and electricity, in the form of the galvanic or sinusoidal current. He claims in several hundred cases never to have been obliged to operate once. (*Mod. Med. and Bact. World*, vol. ii. No. 12, p. 315.)

He calls attention to one point which I consider very important, viz., the necessity for cultivating an erect pos-

ture in sitting or standing. In the common position, with the back arched posteriorly and shoulders drooping, the kidney, as well as all the abdominal organs, are depressed and thrown forward. If, now, the shoulders be thrown back and held down, and the back be arched anteriorly, the abdominal muscles are contracted and all the abdominal contents ascend and are held snugly in place. The position in the rocking-chair, so common to women, is especially harmful. The same arguments hold their importance with relations to pelvic congestions, displacements, and dysmenorrhea. I have known of young women being relieved of dysmenorrhea by simply forbidding them the rocking-chair! There is no doubt that Dr. Kellogg's way is the best; but it takes a well-equipped sanitarium and well-trained attendants to carry out the treatment. If the patient can afford to go to such a place send her there; but we can instruct and insist upon proper posture and such simple exercises as will strengthen the muscles of the back, loins, and abdomen.

The other alternative is a surgical fixation of the kidney, known as nephrorraphy. This is a procedure now well established as eminently safe and surgical. It is also a comparatively easy operation to do, perfectly safe under aseptic treatment, so that any general surgeon can undertake it. It is not within the province of this paper to discuss the operation in detail. I only wish to state my conviction that to insure success, *i. e.*, permanent fixation, it is necessary to strip off the fibrous capsule so as to get adhesion to the kidney cortex itself. Edebohls does not cut off the flap, but turns it over and sews it in with the sutures. On first sight one hesitates to do this, but the kidney substance seems very tolerant, and in most cases there is not even any hematuria; where it has occurred, only during the first twenty-four hours. If the sutures are run down into the kidney tissue proper they should not be catgut, for it is absorbed very quickly in the kidney and is



characteristics be absent, malignant disease being still suspected, the diagnosis may be cleared up by the introduction of a sponge tent. If the cervix soften down, the os dilate, and the mucous membrane become movable under the expansion of the tent, the disease is probably benign. If, on the other hand, the cervix remain hard, its mucous covering immovable, and the os unyielding, the suspicion of malignancy will be confirmed. The so-called cancerous cachexia is undoubtedly owing not to a cancerous diathesis, but to absorption of septic material from the local cancerous lodgment. The cause is evidently topical, and not general or systemic. It is fairly certain that complete removal of all infected tissues in the very first stage of cancer, while the disease is yet local, will effectually eradicate the malady—the patient will fully recover and complete her span of life in health and comfort. It is scarcely necessary to add that a judicious course of constitutional medication should be maintained for a sufficient period subsequently to correct any ulterior or indirect aberrations of health which may have supervened as the result of the primary affection.

With reference to the curative power of drugs in cancer the opinions of physicians vary widely. Arsenic has undoubtedly achieved the highest claim to attention in this disease of any remedy known to us. Does it cure cancer? If it does, then surely surgical interference ought not to be sought in these cases—surgical operations ought not to be practiced in carcinoma.

The statement has been often repeated that chimney-sweeps are exempt from cancer. The explanation of this fact, if fact it be, is unknown to the writer.

Hygienic influences, and especially attention to diet, should receive the careful thought of physicians. It is asserted that those persons who are large meat consumers are easy victims of malignant disease.

It may be laid down as a surgical rule: repair every in-

jury following delivery as soon after its occurrence as circumstances will allow. Strict adherence to this rule would, in the opinion of the writer, within the period of one generation, vastly diminish the concurrent number of cases of cancer of the uterus, and be a long step in the direction of stamping it out. A womb suspected of malignant infection ought to be speedily excised. No other plan of treatment promises success.

The complete removal of the uterus by abdominal section (hysterectomy) or through the vagina (kolpo-hysterectomy) is now so frequently practiced that the rapidly multiplying literature thereon leaves little to add as to operative technique. Perfect aseptic precautions should, of course, be observed. Excision of the womb is a very ancient proceeding. The operation was probably known to the ancient Greeks. Soranos of Ephesus, in his book on "Diseases of Women," published a century before Christ, alluded to it. It is probable that the operation was made for prolapse, and not for disease. The next historical account of hysterectomy appears in 1560, when it is said Andreas à Cruce performed it. A period of more than two centuries and a half then elapsed, when in 1813 Langenbeck successfully removed the whole uterus for supposed cancer by a method alleged to be similar in its essential details to that recently revived and practiced by Pratt. Mikulicz informs us that Gutberlat in 1814 gained a prize in Vienna for proposing an operation little differing in technique from that of Freund. Sauter of Constance made a successful kolpo-hysterectomy for cancer in 1822, entailing a urinary fistula upon the patient. In 1828 Blundell recorded one successful removal of the uterus for cancer, and three failures. It was said at a later day by an eminent British surgeon that the failures were seldom reported. This is as true to-day as when uttered by Keith. In 1829 Récamier, to whom modern gynecology is indebted for the vaginal speculum, records one successful operation. A gap of about forty years now

intervenes, until in 1879 Czerny reintroduced the operation with a successful case. Many additional cases by other operators rapidly followed; the operation quickly became one of the established surgical procedures. Thus we see that within the space of about fifteen years hysterectomy has achieved most of its triumphs. Compared with ovariectomy, statistics show but little difference in the mortality rate between the two operations. While nearly all of the early hysterectomies (especially abdominal) were fatal, the present success is phenomenal. Keith says that all the hysterectomies done in Scotland, where the operation was frequent, up to and including 1879 were disastrous except three, in his own hands, which were successful.

It may be seriously doubted if the ideal hysterectomy is yet perfected. It is equally true that it is impracticable to subject all cases to the same procedure. In a given case, wherein the uterus is too large to be easily removed through the vagina, coeliotomy will be necessary; selected cases may yield to Pratt's enucleation; another kind of case may allow the surgeon to readily tie off the arteries of the broad ligaments, the ovaries, and the tubes; and yet others may require the use of clamps.

I am not aware that, in the hands of the best operators, any one way of doing a kolpo-hysterectomy is more successful than either of the others. Much depends upon the condition of the patient at the time of the operation, and much upon the skill of the operator.

PELVIC SURGERY.

BY

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IN writing upon pelvic surgery it is not my intention to treat the subject in a highly technical way. My object is to touch upon its salient points and draw out a discussion that will obtain from our ablest operators the most advanced and practical thoughts. The progress in all the departments of abdominal surgery during the past decade has been so rapid that it seems hardly possible to keep pace with its teachings. The brilliancy of achievements is equaled only by the boldness of its advocates. What was authority yesterday is, as it were, obsolete to-day. The methods of former years are now not only worthless, but, we might say, pernicious. The old routine practice, the dilatory measures of the theorist, in the treatment of many serious conditions of the pelvic viscera, when viewed by the light of recent investigations, are absolutely murderous.

A knowledge of pelvic pathology is essential to a proper understanding and appreciation of the diseases of this region, and on this factor, more than any other in a physician's acquirement, depends his success in their management. The range of pathological possibilities is more extensive, the consequences of inflammatory products are more serious, and the disintegrating influence of pus is more devastating here than in almost any other part of the body.

Infection of the pelvic structures is usually of uterine origin; the sepsis, passing along the fallopian tube, ultimately reaches the pelvic cavity. An inflammation of the tissue here, in many respects, pursues the same course as elsewhere. The involved tissue becomes congested and

effusions and cellular infiltration follow. In the tubes the irritated mucous membrane pours out a serous discharge, which becomes muco-purulent and quickly infects all adjacent structures. If the distal end of the tube remains patulous the purulent matter is discharged into the pelvic cavity, infecting the ovary and peritoneum with varied consequences; the seriousness of results depending largely upon the virulence of the poison. If the sepsis is mild in character, the inflammation is slow and circumscribed in its extension, the effusion of serum into the areolar tissue is limited, and the vitality of the circulation is not greatly impaired, reaction may follow, and the exudations are carried away by absorption. On the other hand, if the infection is virulent, there is more violent inflammation and a rapid pouring out of morbid products; the deeper structures become involved, the tissue becomes overdilated, the capillary circulation destroyed, and suppuration results. If the accumulation of pus is not early evacuated the most serious consequences follow. When the inflammation invades the fallopian tube the mucous membrane becomes swollen and plastic lymph often occludes the passage; in such cases the accumulation of serum dilates and enlarges its cavity, resulting in a hydro- or a pyo-salpinx, according to the nature of the excreted fluid. The inflammatory exudations into the connective tissue of the tube render it dense and thicken its walls, which often leaves the tube in a greatly hypertrophied condition, and more or less infiltrated with pus corpuscles. At times the uterine extremity of the tube remains patulous; when this occurs the secretions may be discharged into the womb and recovery may result. Occasionally a more important feature of pelvic infection than disorganization of the tubes and ovaries—one that is often caused by delay in operating—is the bowel, bladder, and omental complications. Adhesions and contractions, resulting from the exudation of inflammatory products, cause a distortion and dislocation of organs and

tissue that may be productive of the most severe and uninterrupted suffering, the relief of which is at times of more importance than is a cure of the original trouble.

Since the laws of morbid anatomy apply alike to all regions, so also should the broad principles of surgery govern here as elsewhere. Who would, in this day of surgical progress, aspirate an abscess of the liver, leave an empyæmic pleuritis to a spontaneous evacuation, or a gangrenous limb to Nature's amputation? Yet, if we are to believe what we read, there are those who would treat a pelvic abscess by the expectant method, a disorganized ovary by electricity, or a pus tube by dilating or curetting the uterus. These conditions are to the pelvic surgeon what the former are to the general surgeon, and the evil consequences resulting to the general organism from their mismanagement are not less deleterious.

There is a consensus of opinion among those most competent to speak—experienced operators—that diseased and occluded tubes, with retained secretions and degenerated cystic or suppurating ovaries, never return to a state of physiological health, and that the consequent inflammatory changes, adhesions, and contractions are not amenable to any form of therapeutical treatment. A verification of this fact is demonstrated in almost every specimen removed. There is a sentiment against the removal of the tubes and ovaries that is not based upon knowledge or sustained by rational reasoning. Limited knowledge of the subject and small opportunities are largely responsible for this. It must be remembered, when dealing with the subject, that the purpose of surgery is not always to establish physiological function or restore perfect form and health. The object may be simply to stop disease, relieve pain, or prolong life, though at the sacrifice of an organ or a limb. The fundamental principle is the same when applied to either a womb, an ovary, or a tube. Whenever these organs develop a diseased condition that destroys their function, and the

morbid condition entails unmitigated suffering, their extirpation is demanded, and no sentiment of conservatism should interpose. Pelvic suppuration, ovarian and tubal abscess, chronically enlarged and occluded tubes, displaced and adherent ovaries and tubes that give rise to continuous suffering and impairment of health, as well as many diseased conditions of the uterus, are better and more safely treated with the surgeon's knife than by any therapeutical measures yet devised.

Next in importance to a definite understanding of pathology in the management of pelvic diseases is diagnosis. A vast amount of technical knowledge, tactile sense, careful discrimination, and experience is necessary to form a proper decision as to the condition and requirement of a case. Where a correct knowledge of morbid processes and accuracy of diagnosis obtain in pelvic surgery, there can be but little adverse criticism upon the results. It is the abuse of surgery—the performance of operations upon insufficient data, the misconception of the true pathological condition and its demands—that has brought pelvic surgery into disrepute with the general practitioner. Delay has also done much to discredit this branch of surgery, and many valuable lives have been sacrificed through the irrational belief that a laparotomy is extremely hazardous and should be performed only as a last resort, after every therapeutical makeshift has been employed. Operations that could be easily and safely done early, that would restore the patient to perfect health, are postponed until the entire pelvic, and possibly the abdominal, viscera are involved. Pus has burrowed in every direction, plastic exudations implicated and molded together in an unrecognizable mass uterus, ovaries, tubes, bowels, and bladder, occluding intestines and distorting parts until not a natural feature remains. Though life should be saved by an operation, the pains and aches incident to adhesions render the patient's existence intolerable. These and the cases operated upon for pain,

hysteria, epilepsy, insanity, etc.—cases without demonstrable lesions—go largely to make up the list that is arrayed in double-headed columns, a protest against pelvic surgery.

Opening the abdomen is not necessarily a serious procedure. Danger lies not in the traumatism; sepsis through contaminated hands, instruments, or infected tissue endangers life. Skill in operative technique and a conscientious observance of the laws of antiseptics are life-saving features.

Perfect and complete work should obtain in every case. An operation once begun, no matter how unpromising the case may seem, should be finished in every detail; nothing should be left undone with the belief that the patient must die; that very thought may engender neglect that will cause death. The most desperate cases, where the operation is carried to completeness with exactitude, often recover. Adhesions must be carefully and intelligently broken up, purulent pockets and sinuses thoroughly eradicated, suppurative tubes excised close up to the uterine cornua, cystic and disorganized ovaries removed complete, all injuries done to the remaining viscera repaired, the abdomen flushed and drainage applied, when necessary, and last, but not least, the abdomen accurately closed.

One of the most important elements in successful pelvic surgery is drainage. While it is not advisable to drain in every instance, when extensive adhesions have been broken up, or a possible leakage from an abscess or a pus tube has happened during its removal, drainage is a necessity. He who drains in such cases will certainly be rewarded by the greatest percentage of recoveries.

The kind of drainage to be preferred depends much upon the condition. When adhesions have been extensive, leaving a large surface of denuded peritoneum which will cause much exudation of serum, if non-infection can be assured, the glass drainage-tube will answer. It should be scrupulously attended, and left remaining until all fluid has ceased to flow—from one to three or four days. When pus has



been encountered, or any of the viscera has been injured, iodoform gauze should have the preference. It keeps dry every recess, walls off the infected regions, prevents the circulation or migration of fluids, and by its sterilizing properties renders inert the micro-organisms. It should be used in abundance, placed deep in the cavity, allowed to protrude through the abdominal wound in one roll, and left undisturbed in its position until all drainage ceases. When the gauze is used the dressing should be bountiful, sterilized, very absorbent, and frequently changed.

The closing of the abdominal wound demands as much deliberation as any other part of the operation. Two rows of sutures are essential, one deep, buried, and one superficial. The cut surfaces of the peritoneum and muscular tissue should be accurately coaptated with a medium-sized catgut suture, and the superjacent structures carefully brought together with silk, snugly, but not tightly, drawn, and perfect and even adjustment of the skin assured by the introduction of an occasional superficial stitch. In introducing the approximating silk suture a curved needle should be entered near the cut edge, passed outward, downward, then inward with a sweeping curve, emerging below in the muscular layer, but not piercing the peritoneum, then re-entered on the opposite side and passed with the same curve upward and brought out in the skin at the same distance from the cut edges. This procedure insures the coaptation of every part of the abdominal walls; besides, as there is no drawing on the skin, it largely obviates the cutting pain and soreness incident to ligature tension. Hernia will never result when an abdomen is closed in this way. There are other points upon which I would like to dwell, viz., anæsthesia, the length of the abdominal incision, the Trendelenberg position, after-treatment, diet, etc., but I feel that I have now occupied too much of your valuable time.

## HEMORRHAGE FROM THE BREAST.

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IN view of the fact that scientific obstetrics has been practiced since 1550, and as there is plenty of evidence about to show that it has been pretty generally practiced, it would seem to be impossible to give anything new in the realm of that art or science; and we will claim nothing more in this paper than that the experience detailed in the following case is new to us, hoping by recounting its details to arouse our colleagues to a more general recording of their experiences.

Mrs. B., three months after confinement, was much alarmed by her infant's vomiting blood in large quantities, so much so that she sent in haste for the nearest physician, reporting that her baby was having a hemorrhage. Upon examination the physician was soon convinced that the fault was not in the child, but that the blood had been swallowed while nursing. The quantity was as great as the amount of milk usually taken at a single nursing, and sufficient was retained to stain the passages through the bowels for more than twenty-four hours. Having decided that the child was in no danger, he turned the case over to me, the attending physician. My first impression was that the blood had come from fissures about the nipple, but examination removed this condition as the origin of the blood. Further examination revealed what appeared to be a mass of congested blood vessels deep in the center of the gland. The child was not allowed to nurse from that breast for a couple of days, the breast pump being used to relieve the pressure in the gland. The blood soon disappeared from the milk, only to return when the child was

allowed to nurse for any length of time. At each reappearance we again had the congested blood vessels present. The gland, previous to this time, had been performing its function normally, and had shown no evidence of inflammation, but immediately after the first hemorrhage there was a rise of temperature, and active treatment became necessary to prevent inflammation. It was finally determined not to use this breast—the left—longer, but to rely upon the other for the child's nourishment. In another week the same phenomenon occurred in the right breast. Finally, by using the breast pump, the blood gradually disappeared, only to return when the child was allowed to nurse. I neglected to say that Mrs. B. was a primipara, and also that in addition to the discovery of the tumor the breast, immediately after the first appearance of the blood, rapidly increased in size until it reached nearly twice its original volume, and also seemed to be lifted from the chest.

Not being able to find any explanation for this, we will have to look to the anatomy and physiology of the gland. Remember that, normally, the glands are situated between the skin and the pectoralis major muscle. From the latter they are separated by layers of superficial fasciæ forming a bursa. The gland, in its structure and arrangement, is composed of secreting tubules which open into common ducts; these ducts are surrounded by a complete network of anastomosing blood vessels. In other words, the gland is segregated by layers of fasciæ, between which it yields to pressure, and while they segregate, they also unite the several lobes into which the gland is divided. We find many diversions from what we call the normal anatomy of the breast. Instead of the fasciæ forming a bursa to separate it from the pectoral muscle, sterno-costal cartilages, and the ribs, it may be deficient in parts; portions of the gland may project through the fasciæ and be constricted by them; and when called into activity this constriction may account for congestions with subsequent inflammation. Again, the

gland may be deficient in parts, while the distribution of blood vessels may remain normal.

The physiology of the gland shows that it is rudimentary at birth, developing as the woman develops, but always having its function latent until excited by the child in utero. As soon as the uterus no longer requires blood for the support of the fetus it is diverted to the breasts to furnish nourishment through the lacteal fluid. The function which has formerly laid dormant now depends entirely upon the natural excitant, and there is only one—the mouth of the sucking child. We believe it to be a fact that the character of the milk progressively changes from the birth of the child until it reaches perfection as to quality and strength, the whole gland having then reached its full development, and the child requiring nourishment of the highest standard.

Any diversion from the anatomy as given above shows the possibility of the condition described in the case presented. Physiology explains why the condition was not developed until the third month after confinement. The appearance of the high temperature and tendency toward inflammation after the hemorrhage, with the subsequent enlargement of the gland, is simply in the line of the development of parenchymatous mastitis, due to the engorgement of the gland with its normal secretion.

It is natural to ask what the doctor did about this. He gave lyc., because he had learned that lyc. did more good for hemorrhage from the nipple than any other remedy. Failing in that, he fell back upon the usual methods of treatment in cases of mastitis. Bryonia was indicated by the condition of the gland, aggravation from motion, a tendency to vertigo upon moving the head, great thirst, etc. Conium was called for after bryonia. Locally he sweated the breast after the usual method, which is to apply hot applications for the period of twenty minutes, following them by bathing with warm oil, then covering the breast with

absorbent cotton. This process was repeated every two hours, the breast pump being used to draw off the excess of secretion. After the acute symptoms had passed he had the patient wear over the breast a piece of rubber dam. The treatment prevented, we believe, the formation of an abscess. Aside from that he does not feel satisfied with the result, as he was not able to restore the gland to its normal function, though it has returned to its normal shape and size.

With the assistance of Drs. G. W. N. Custis and Ira W. Dennison we have gone over, as thoroughly as possible, the literature of lactation, as well as that of diseases of the breast, and fail utterly to find but two other cases recorded of abnormality as regards the secretion of the mammary gland: Habergritz reports that from the breasts of a patient, a primipara in the sixth month of pregnancy, drops of blood could be pressed. Two days before delivery the blood disappeared, to be again secreted in increasing quantity after labor. There was no blood taint or organic disease present to account for the condition, which Habergritz suggests may have been transuded blood, which was intended later to form the colostrum and milk. Under diet and secale the secretion finally lost its blood color and became blue-white. The mother nursed the child and both did well. Landau reports another case where the milk from one breast was sweet, while that from the opposite gland had a salty flavor. All other cases where blood has been discharged from the breast have either been those of vicarious menstruation, of which there are several cases; where it was mixed with pus from a mammary abscess; or in connection with cases in which there were manifestations of malignant disease of the gland.

Having had some experience with bitter and salt milk, we naturally turn to our own literature, and find, in that storehouse of knowledge the homeopathic materia medica, the only reference to milk abnormal as to quality. The

Encyclopedia speaks of bitter milk, salt milk, milk deficient in casein, butter, or fat.

In the provings of the remedies according to the *materia medica*, "The Chronic Diseases," rheum is said to have caused the milk of nursing women to turn bitter. As far as we can learn, the symptoms given under acetic acid and calc. phos. are clinical, showing that such conditions have been observed by the physicians of our school, though they offer us nothing as to the causes of this phenomenon.

We take this opportunity to repeat the claim that the intelligent application of our laws of necessity makes our school a class of close observers. Therefore, if we do not allow ourselves to be biased or dazzled by the appearance of wisdom shown by our opponents, and work independently after the inductive methods taught by our own school, we will be the first to reach the truth as to the ætiology of disease, and be the first to discover the true method of its prevention.

We know that many drugs are rapidly taken up by the milk—opium, for instance. Professor Fehling reports a case of the mysterious death of an infant from an overdose of morphia, which seems to have been conveyed from the nurse through the milk.

Most of the changes in milk resulting from pregnancy and menstruation have been theoretical. The experiments made by Slichter show that the milk during the period of menstruation compared favorably with that furnished prior to that date. He concludes by asserting that after the sixth week menstruation can have no deleterious effect upon the lacteal fluid. Of course we all know that this has exceptions, as we have all seen cases in which, during this period, the children were made sick by the milk.

The result of observation as gleaned from the literature of the subject, as well as from experience, is that, with the exception of a few individual cases, chemical analysis will show but little change in the milk of nursing women due

to special substances taken as articles of diet, the effect upon the nursling being the only means of detecting differences in milk due to such causes. Mental emotions show a greater effect on the quality of milk than any article commonly used as diet. Alcohol, used in excess, has been known to affect the child, though it could not be detected in the milk by any means at hand. As all substances must be assimilated, or at least be conveyed through the blood, before becoming part of the milk, the only means of directly affecting the supply or quality must be through the blood supply to the mammary glands.

Dr. Dolan shows that drugs derived from the families Liliaceæ, Cruciferæ, Solanaceæ, and Umbelliferæ most readily impregnate the milk, so that drugs derived from those classes must be given with caution to nursing women. Belladonna, and possibly camphor, are the only drugs that seem to directly decrease the flow of milk, while jacaranda, agnus cas., and possibly castorium, are the only ones that increase it, so far as we know, from a physiological standpoint.

We append here Dr. Leed's analysis of the mother's milk, believing it to be the most accurate:

Water,	. . . . .	86.766	per cent.
Total solids,	. . . . .	13.234	"
Total solids not fat,	. . . . .	9.221	"
Fat,	. . . . .	4.013	"
Milk sugar,	. . . . .	6.997	"
Albuminoids,	. . . . .	2.058	"
Ash,	. . . . .	0.21	"

Our experience teaches us that homeopathic remedies corresponding with the salts of the milk, when given in cases where they are deficient or in excess, may, by the correction of their assimilation, when taken as food, meet the faults resulting from malnutrition, malassimilation, or faults due to the secretory powers of the gland itself. We have

of these salts among our remedies already proven *natrum mur.*, *kali mur.*, *natrum carb.*, *calcareo carb.*, *calcareo phos.*, *magnesia phos.*, *natrum phos.*, *ferrum phos.* (?), and *natrum sul.* (?)

Anise has been known to flavor the milk, though it could not be detected; ammonium carb. has been found in the milk when given in repeated doses, and the child has been known to refuse milk because of the effect of *copaiva*. Iodide of potassium, after having been given to a mother nursing an eighteen months' child, was found in the urine of the child. Opium in large doses has been detected, and rhubarb, as we have stated before, makes the milk bitter.

In conclusion we draw the inference that it is necessary, before passing judgment upon the qualifications of a nurse, or the possibilities of any woman as to nursing, to see that there is perfect development of the gland, and consistent diet. By consistent diet we mean diet in harmony with the life and surroundings of the nurse. For example, a woman from the country with a perfect breast, and with milk of the standard quality, if brought to a city home, with the consequent change in methods of living as to surroundings and food, would fail entirely as the wet nurse for the child of a patrician; while if the same child were taken to the nurse's home it would gain in strength, and possibly be able to overcome many of the constitutional weaknesses resulting from the surroundings at its birth.

That, as far as we know, homeopathic medication, with the quality of the milk as an indication for the remedy, taking the peculiarities of the patients in connection with their disease history, offers the only means known to science at the present time for the improvement of the secretion of the mammary gland aside from hygienic measures known to all, whether that improvement be necessary in quality or quantity.

That the effect upon the child as to the movements of



its bowels, its increase in weight, its ability to sleep for the required time, its willingness to take the breast in preference to artificial food offered with the spoon or cup, are the only tests that are always reliable as regards the quality of the milk.

As our interest has been awakened in this study, we promise more in the future, and express the hope that this bureau will make itself a committee for investigating this most interesting subject.

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### DYSTOCIA—A RARE CASE.

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BY

S. P. HEDGES, M. D.,

CHICAGO, ILL.

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MAY 14, 1893, was called to attend Mrs. X. at the birth of her first child. Patient thirty-four years old, brunette, medium size, in good flesh and strength, spirits and courage good. She had always enjoyed fine health. I had been engaged for the case several months before, and had examined her urine two or three times toward the close of gestation and found it normal.

She expected to be confined about June 20, her last menstruation occurring September 15, 1892. She was "tired and worn out," as she said, waiting so long over her time. Her pains came on about 10 P. M. July 14. They were weak and irregular. Nurse was with her, and I was not called until early in the morning of the 15th. She had rested but little through the night—was up and down. On examination I found the os firm and thick, dilated only to size of a nickel, membranes unruptured, head presenting, parts rather dry. Ordered hot sitz bath, prescribed pols. At 9 A. M., on returning, found some progress; pains were

regular and harder. Ordered another sitz bath. At 12 M. dilatation well advanced—larger than a dollar. I noticed that during the pains, which were expulsive in character, there was no effort of head to engage. As the pains were fairly good and patient was brave and willing, I encouraged her by saying that she was doing well. After waiting two hours there was still no advance. It was now 2 P. M. Hard, bearing-down pains for three hours. There were no discharges. There was scarcely a bag of waters to be detected during a pain. However, I ruptured the membranes, and after much difficulty made out that the vertex was presenting, occipito left anterior. I realized at this stage that there was some cause of obstruction. I administered chloroform and began a thorough examination. I found the pelvic diameters of ample dimension. But the presenting part I observed was immovable by any pressure from below. It was fixed and still unengaged at the superior strait. On examination of the abdomen I noticed that the gravid uterus was tense and hard and gave the appearance of having two babies in it, one above the other, with a constriction between them—a kind of hourglass contraction. I thought there might be twins, and yet the presenting head was too large, seemingly, for that. The uterus was very sensitive to bimanual examination, even under the anæsthetic.

I was puzzled to understand the cause of the condition. Before and up to this time the pains had been strong and caused great suffering. I hoped the anæsthetic might aid in advancing the labor. During the last three hours I had administered bell., cim., and cham. in succession, with no effect. I now allowed the patient to recover from the chloroform. The agony was painful to see; the pains however, were becoming powerless. No advance was perceptible. The strength and courage of the little woman were exhausted. The husband and mother of the patient had desired me to avoid the use of instruments, if possible.

The patient said she had felt no motion since noon. I was unable at any time to discover the fetal heart-beat. At 5 P. M., after the patient was fully anæsthetized and placed in the obstetrical position, I prepared to use the forceps. I had very good help for lay help, but the undertaking was a difficult one. An experience of nearly thirty years in the use of the obstetric forceps was all brought into play and needed. After a half hour of hard work the forceps were finally adjusted and locked, leaving only some four inches of the long forceps protruding. And now the labor began for the doctor as well as the patient. Fortunately the harder I pulled the stronger became the pain. The head slowly descended to the perineum. It made no advance except by hard pulling. The head was hard and large, and the perineum was ruptured back to the sphincter ani. The head was delivered, the forceps removed. The child had been dead some hours. The head and neck were a dark, greenish yellow, like an old case of pernicious jaundice. The whites of the eyes were deep yellow. The pains still continued, but the fetus was tight and locked and seemed immovable. With difficulty I worked my finger up and under the axillæ of the infant on each side and began traction. After a long and steady tug it came with a rush. The appearance of the babe was striking. It seemed nearly cut in two just below the lower ribs. If a large rope an inch in diameter had been drawn around the middle of the child with great force and continued for many hours it would have caused just this condition. And there was revealed what had been the cause of the dystocia, namely, a case of hourglass contraction before the delivering of the child, cutting the fetus nearly in two about the liver. The bile in the liver and gall bladder was forced back into the circulation while the child was still alive, thus accounting for the color of the child, which was all over a deep yellow color.

Tying and cutting the cord, I gave my attention to the

delivery of the placenta. I did not wait long, and on examination found the placenta was retained above by a very firm hourglass contraction. The patient was very seriously exhausted and haste was needed, so preparing my right hand and arm, I carried my hand, after a great effort, above the obstructing bands and detached the placenta, and by kneading the walls of the uterus by a bimanual action I brought on contraction, and found my hand and the afterbirth slowly forced from the uterus. The contraction was firmly continued and persistent. I then finally completed with primary perineorrhaphy, a careful obstetrical and antiseptic toilet and placed patient in bed. She made a steady and uninterrupted recovery and has enjoyed perfect health since.

This case is reported on account of its being so uncommon. It is the first case of the kind I have met with in twenty-eight years of active practice. I have not found a physician up to this writing who has met with one, nor do I recall a case in the books or reports in the journals. No author speaks of it in the books I possess. Among the maternal causes of dystocia this is not mentioned. The occurrence of hourglass contraction as a cause of retained placenta is not infrequently met with by most of you. The causes for this irregular spasm of the circular fibers of the uterus may be many, but they are mainly unknown. There was nothing wrong during the gestation, so far as could be noticed by patient or doctor. Just when this contraction began is uncertain. The lady never recognized it. I first noticed it when searching for the cause of the delay in the descent of the head after hours of hard expulsive pains. Even then I thought it was a case of twins, and that they were locked and thus obstructing the advance of the presenting part. I can conceive that if such a case occurred in a breech presentation it would demand an abdominal section if the child were to be saved, if indeed it might not be necessary in order to save the mother. But

as the head presented, the firm hold of the forceps gave such control and power of traction as to overcome the great resistance. I think the forceps were on one hour before the head was delivered. The axillæ then gave a chance for further traction, and so the child was delivered. By the breech presentation none of these advantages would be possible, and even if the body had been brought below the stricture it would have shut up tight around the neck like a steel band and defied every effort at delivery. I think I shall never have a case of difficult labor again that this contingency will not come to my mind. All rare and difficult cases in the obstetrical practice of any of us, when reported, add by so much to the experience of each. Thus we multiply our individual experience by that of all the rest.

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### POST-PARTUM HEMORRHAGE.

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BY

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POST-PARTUM hemorrhage, or flooding, as it is known in common parlance, is a profuse flow of blood from the uterus following the delivery of the fetus, and may occur either before or after the delivery of the placenta. It is a condition we are liable to meet when called to the bedside of the parturient woman, and it is one with which we should be very familiar, not only with the causes that produce it, but thoroughly conversant with its proper treatment, mechanical as well as medicinal, and as Dr. Gooch has well said, "No physician should have the hardihood and assurance to cross the threshold of a lying-in chamber who is not thoroughly conversant with the remedies for flooding." In order the better to understand the avenues from

which it is possible for such a profuse flow of blood to occur, let us for a moment consider the anatomical construction of the placenta in reference to its attachment to the uterus.

Here we find the villi of the chorion, made up of a network of capillary blood vessels, on the fetal side dipping down into the meshes of the decidua serotina, where they meet the uterine blood vessels, which have also penetrated the decidua serotina, the two sets of blood vessels coming in direct contact, the walls of the two uniting, thereby forming a membranous septum, which separates the maternal blood from the fetal. This membrane becomes very thin as the union progresses, and it is through this, as the two bloods cross in their own channels, never mixing, that the fetal receives its nourishment, and gives up to the maternal its deleterious matters by the process of osmosis. The vessels thus formed are the so-called utero-placental sinus of some authors, and it is from these that the blood pours forth as the water from a gushing fountain, when this union is severed as the result of the delivery of the fetus, and following this the removal of the placenta, which leaves the uterine half of the sinuses gaping whenever the course of nature is interrupted. These uterine sinuses are closed, or partially so, by the formation of emboli in them, but more especially so by the contraction of the womb. This failure to contract may be the result of uterine inertia, from a long and tedious labor wearing out the uterine muscular walls; from the severity of the pains or contractions, as in a precipitate labor resulting in shock from the suddenness of the collapse; from overdistention, as in a case of amniotic dropsy; from the wall of the uterus being thin and undeveloped; from malformation or malposition of the uterus, and in addition being bound down by peritoneal adhesions; by the existence of tumors, either intra- or extra-mural. Or it may be the result of a generally weakened and run down constitution, such as we find in anæmic or tubercular patients;

or it may be produced by the mental state of the patient, such as we find in one who has already passed through the ordeal and has the dread of its recurrence uppermost in her mind. The symptoms are both subjective and objective. Subjectively we have the patient calling you suddenly to her side to ask you what can be the matter, she feels so strange, so dizzy; she can't get her breath; she feels so weak and can't see and implores you to do something for her; she fears she is going to die.

Objectively on feeling her pulse you will find it very fast, soft, and thready, hardly able to find it; and whenever the patient's pulse does not slow up after delivery take warning and watch your patient very closely, for you have trouble ahead, and stay close by your patient so as to notice the first signs of impending danger. You will notice the pale face and pinched features, and she will tell you something hot is flowing from her, and on examination you will learn she is not mistaken, for you will find her lying in a pool of blood and clots; or it may be a concealed hemorrhage, the neck of the womb being blocked by the placenta. On external examination in the hypogastric region you will notice the entire absence of the cannon-ball contraction and instead a flaccid and fully distended womb, and if the patient be a multipara entire absence of the afterpains. This symptom will be absent in primipara or nearly always so, as they very seldom feel the contraction of the womb after the labor is completed.

Before taking up the subject of treatment I will briefly enumerate the instruments, drugs, and other articles which will be of use to you. In the instrument line, in addition to the usual obstetrical set, the accoucheur should be supplied with a good Davidson syringe, a large male catheter or a recurrent uterine douche, and a good hypodermic syringe, a can of iodized gauze, and plenty of hot and cold water and ice. In addition to the remedies usually carried in the buggy case he should have a bottle of the best fluid extract

of ergot or ergotine, a bottle of tincture of geranium, a bottle of Monsel's solution of persulphate of iron, and some vinegar, which can usually be obtained from the family larder.

Let us now take a typical case and follow it through this period. The labor has progressed favorably, the fetus is delivered, the cord tied and sewed, and the baby has been turned over to the tender mercies of the nurse and you have returned to your patient. You feel her pulse, and although the cord has ceased to beat, indicating to you that the placenta is detached, yet the pulse remains very high. You become alarmed, and while you place your hand over the womb in the hypogastric region, you discover that the womb has not contracted, and at the same time you notice the subjective symptoms enumerated above. Having removed your coat and rolled up your sleeves, with your left hand grasping the womb above, on examination you find the patient lying in a pool of blood and the current still flowing as from a hydrant. You now have no time to lose; what is to be done must be done quickly. Fill your hypodermic syringe with fluid extract of ergot—it is taken for granted that you have already given your patient a dose of arnica internally or aconite if there is that fear of death—and inject it under the skin over the womb. Having done this you now deliver the placenta, using force and even peeling it from its moorings if necessary, at the same time kneading the womb with your left hand. Introduce your right hand into the womb and empty it of all clots, and irritate the endometrium with your finger; this will act as a stimulus to the relaxed uterine walls. If now the womb does not contract introduce a piece of ice on your hand, and also apply ice or cloths wrung out of ice water over the abdomen. Should you now fail, irrigate the womb with hot water with persulphate of iron or vinegar added, one ounce of the persulphate to ten of water, or equal quantities of vinegar and water, or the vinegar pure, first being sure there are no clots left in the womb. Should the womb still fail to con-



tract or the hemorrhage continue, then pack the womb with the iodized gauze. While you have been thus engaged you should have had the foot of the bed elevated by some of the attendants, while others might be engaged in slapping the patient on the face with a towel or handkerchief wrung out of cold water. Always have the friends busy doing something, for if you don't they will be constantly talking and suggesting all manner of things, which would do nothing but alarm the patient and add to her terror, for by this time, if she has not fainted, she will be imploring you and each one present to help her. You should have the baby placed to the breast by all means, for often you will be rewarded with a firm contraction of the womb with the first draw made by the baby, the two systems of production and nutrition being very closely united by the sympathetic system of nerves. As a last resort try the ligation of the extremities, the arms and thighs, thus preventing the return of the blood from these parts. If now you fail, after having given the homeopathically indicated remedy internally and tried all these expedients, you will have nothing to reflect on yourself, as you will have done all that mortal man could do. Should you succeed in checking the flow your work will be only half accomplished, for though you have saved the life for the time being, you will have a patient on your hands so weak and prostrated from the shock to the nervous system and from the loss of blood that only patient care and constant attention can save from a lingering death, as septicæmia may follow.

Before considering the homeopathically indicated remedies there is another condition following a normal labor that we must not overlook in this connection. It is secondary *post-partum* hemorrhage. It will occur anywhere from one to three or four days after you would suppose your patient is getting along nicely. It may be the result of retained secundines, or small emboli that have been caught in the sinuses as the womb contracted, by the use of alcoholic

stimulants used too freely and too soon, by too much exercise, or by emotions, or by lacerations of the cervix, by an inverted womb, fecal impactions, albuminuria, or anæmia. The hemorrhage may occur and stop and recur again from day to day; may be quite profuse or only slight.

The treatment will depend entirely on the cause. If from an inverted womb, return it to its normal position and conditions; if from retained secundines, curette the womb and irrigate thoroughly; this should also be done in cases of septicæmia; if from fecal impactions, remove these; if the result of anæmia or albuminuria, give the patient the properly indicated remedy and proper food and exercise.

The remedies most frequently used are arnica, china, crocus, hamamelis, secale, sabina. Geranium both internally and locally. It is a splendid astringent remedy, as it contains strong traces of gallic and tannic acids. For the special indication for each I refer you to our materia medica and repertory.

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## POSTURAL TREATMENT IN DISEASES OF WOMEN.

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BY

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COVINGTON, KY.

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**I** SHALL not attempt an exhaustive treatise on this subject, but only to give you a little of my own experience, trusting it will incite discussion and thereby become beneficial to you.

Some time back there came into my care a case of menorrhagia in a young lady about twenty-eight or thirty years of age. The hemorrhages were profuse, with great prostration not only at the periods but between them, this

prostration increasing until the patient was unable to leave her bed. When she would try to sit up she would complain of something giving way in the pelvis. She was cheerful, happy, and easily excited. Digital examination revealed a prolapsus in the first degree with retroversion, and so great hyperæsthesia of all the parts that any attempt to reduce the displacement was impossible. *Lilium tigrinum* 6x for two weeks, or until after menstruation, then *platina* 2c, two doses, and the genupectoral position every three hours, retained as long as the patient could endure. This postural treatment was continued throughout the summer, with *conium* 2c, one dose before each menstrual period. The patient is now able to sweep, walk a mile or more, and attend to household duties. Since that time I have tried this position in several cases both of prolapsus and dysmenorrhea with marked relief. I have also used it successfully in a case of nausea in the last months of pregnancy. This is the most important of all postures in the treatment of diseases of women.

One of my patients who disliked the genupectoral position, of her own accord assumed another that seems even more valuable than the one prescribed, because less cramped, and one which I have never seen recorded, viz., placing the thighs on the bed, patient's face downward, the forearms on the floor, thus inverting the pelvic axis, leaving the abdomen free from all pressure; the uterus by force of gravitation, unless secured by adhesions, assumes the normal position.

In parturient women malpositions may be permanently removed by postural treatment. As the uterus returns to its normal size, see to it that its position is normal also.

To the habit most women have of sitting on the sacrum when tired is due the tendency to retroversion, so frequently found in all classes of women irrespective of diseased conditions. The uterus in its relaxed condition falls against the rectum; this, continued, passes easily from habit

to disease. For such cases postural treatment is one of the "most reliable and safest" means of a "speedy, gentle, and permanent restitution of health," which our great leader claims to be "the highest aim of healing."

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## RANDOM THOUGHTS ON OBSTETRIC PRACTICE.

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BY

SILAS C. WHITCOMB, M. D.,  
ONEIDA, ILL.

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**I**F in the practice of obstetrics only there was to be found need of more thorough education, according to my observation the necessities demand all that has been said upon the subject.

It was my good fortune to enjoy the benefits of a special course (two courses, in fact) in addition to the regular lectures. While the regular course was full and complete, it was not upon the Episcopalian plan, *i. e.*, we could not talk back. In the special course we had that privilege; and there were elucidated all the darker points, and thorough practice on the manikin was enjoyed, but for which I fear I would have had poor success, and possibly found myself in the embarrassing situation which one of my "regular" brothers experienced.

At two different times, after waiting two or three hours, he called counsel and assistance to remove the placenta from the vagina. Although a graduate of a regular school, he supposed the secundines should be wholly expelled by nature.

My first case was a "forceps" case. I was not hasty in diagnosis, as the patient, a primipara, had been in labor twenty-four hours, carefully attended by two old aunties.

I found the head firmly lodged at superior strait; all efforts to dislodge it fruitless. During my half hour's absence to get my forceps she had a severe attack of vomiting, and I was pleased to find that the first pain thereafter advanced the head materially. I did not use the forceps, and in all cases of dystocia I have since regarded as favorable a like gastric disturbance.

Ruptured perineums under the "old masters" was the rule. Some of them are yet in active practice, and on account of their *age* and *experience* are often preferred, and continue to "let nature take her course." If the poor victims could reach the gynecologist the situation would not be quite so bad; but many of them have husbands like one lately reported in one of the journals. His wife suffered with a tumor. Consulted a specialist, case diagnosed, he asked cost of operation; this was made very reasonable, but it was too much for this skinflint of a husband, who left the office with the remark, "Mary, you can keep your tumor."

I do not think it possible in every case to avoid *quite serious* ruptures of the perineum; yet in most cases the danger can be reduced to a minimum.

I never hurry a labor, and invariably I retard it in the latter part of the second stage. I deliver the head or presenting part between pains if possible. I require the patient to open her mouth, and thus avoid expulsive effort.

At least one-half of my initial calls have been only after labor came on. This is not right, and displays ignorance on the part of the laity. I have invariably advised that I be given at least three months' notice in subsequent pregnancies, and consultation and treatment if the woman is not perfectly healthy. In this way I have saved both pain and life.

I have in mind the case of a stillbirth at the eighth month, the second one this woman experienced. The first she attributed to a fall, and the doctor who attended her then

told her she would never have a living child. The second time she had no fall, was very careful, and yet at about the same time as before she miscarried, the child having been dead about two weeks. I could attribute the accident to nothing but mental impression, as she bemoaned her fate, which she now thought doubly fixed. I soothed her as best I could, told her the old doctor was mistaken, and promised if she again became pregnant to give her medicines that would prevent such a result. In due time she came to inform me she was pregnant, and wanted the promised medicines. I gave her *cimicifuga* and *pulsatilla* in the 3x dose night and morning in alternation after the sixth month, insisting on usual exercise (with care), and promised her a living child. She went to full term, and had a fine live boy. Since which time she has borne a daughter—no more abortions.

I was called to my only case of placenta prævia so late that the woman was fainting from loss of blood. The nurse informed me the "waters" had broken some time ago. On digital examination I found the membranes intact, placenta covering os, still adherent; with a sweep of my finger I separated it as far as I could reach, ruptured the membrane, and gave my attention to stimulating the patient. There was no more flooding, and in two hours' time I delivered a large male child, which, however, was dead. In this case I gave brandy freely and continued it during convalescence, together with milk diet. I think stimulants are demanded in these cases.

One meets with strange experiences among country folks. Many of them think if a woman comes through labor and lives it is all right; consequently the so-called midwife mismanage a great many cases.

The most remarkable case of obstetric surgery that I have ever heard or read of occurred not far away. It was a footling presentation, and all went well until the arms caught the brim and arrested the descent. The physician, who

was a regular graduate and licensed, was for a moment nonplussed, when the happy idea struck him to divide the body at the trunk and turn the upper portion, which I am credibly informed he actually did, by the aid of the family butcher knife. His efforts at version were futile, and he had to send several miles for assistance. This doctor proved to be a genius, and as he was several miles from his office, without instruments, he utilized an ordinary button hook, which he anchored to a rib, and succeeded in making sufficient traction to reach and bring down the arms.

I have recently heard of an obstetric nondescript in our own honorable school, the first and only case of its kind coming to my knowledge. This man goes to the patient of a brother, also a homeopathist, and an honored member of this society, and says:

"Dr. — charges you ten dollars in cases of confinement; I will attend you for five."

The thought of such pusillanimity quite overcomes me, and I close.

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## RIGID OS UTERI: A CASE.

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BY

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IN presenting a paper in consideration of so common a complication of labor as rigid os uteri I would not presume to claim that I had had any experience that would be of value to anyone; but in presenting "a case" I do so in hopes of eliciting some information that may be of service to myself should other similar cases arise. Aside from its surgical features the case may be of some interest from the

standpoint of the use of that much mooted remedy ergot, which was here used in all disregard of the commonly accepted sphere of the remedy.

In October, 1892, I was called upon by a young man to go and see his wife, who, he said, had just had a miscarriage. Upon making my visit I found the case to be as follows: The young woman was the mother of one child about two years old, and was pregnant four months with her second. Two days before I saw her she had sat upon the cold curbstone watching the Columbus Day parade, and that night was seized with pains, followed by slight hemorrhage. Early the next morning the bag of waters broke, followed by profuse hemorrhage and what was thought to be the fetus, but which subsequently proved to have been nothing but a large clot. Thinking the trouble all over, I was not called in till that (the second) night, when a return of the labor pains led to the suspicion that all was not right. Upon examination I found the fetus still in utero, and the os dilated to the size of a half dollar. The fetus lay at right angles with the long axis of the uterus, and consequently directly across the cervix, and upon making digital examination my finger came in contact with the chest of the fetus.

The pains being unsatisfactory and the os quite unyielding, I turned my attention in this direction, giving belladonna, caulophyllum, gelsemium, pulsatilla, etc., and using tampons, but without effect. Finally, after having been on duty from 9 P. M. till 3 A. M., I resorted, in sheer desperation and with some misgivings, to ergot, the pains having disappeared entirely and the os being rigid as ever. After my patient had taken 10 drops of the fluid extract of ergot every half hour for a few doses, the pains returned and became very severe, though perfectly regular. Still no change in the condition of the os. I could pass my finger well beyond the os and all around it, and it felt as hard and unyielding as an iron ring. I was fast becoming worn out



and was confronted by two possibilities, viz., first, septic infection should the fetus remain much longer *in situ*; second, the case passing into other hands, the family thinking I did not know my business. I sat on the side of the bed for a long time with my finger within the os, speculating on what could be done. I knew that in a great many cases the cervix was torn, and often badly so, and it occurred to me that it might be cut through with even fewer evil results, though I had never heard of such a measure having been adopted. Finally, after debating the matter pro and con with myself, I took a curved bistoury and during a pain passed it, lying between my fore and middle fingers, well within the cervix and cut my way out and clear through the os. Perfect dilatation followed quite naturally enough, but because of the transverse position of the fetus, and because of the impossibility of turning it, the waters having all escaped long before, I had to tear the fetus through with my finger and deliver the upper and lower halves of the body separately. My patient suffered no more pain than usual, and when I left her a half hour after the fetus had been removed she was falling asleep.

Upon reaching home, and before going to bed, I turned to my books to see if I had any authority for such a procedure, and found (Schroeder, Playfair) that incision of the os is sometimes admissible, but only after all other efforts have failed.

As for the patient, no one could have made a more perfect recovery, and she is to-day, eighteen months after, in perfect health, without a symptom of any kind, much less a symptom that could be traced to my heroic treatment of her os. Had I been provided with Barnes' bags I might have been saved the necessity of adopting so questionable a method, but I had neglected to take the bags with me and simply did what seemed most expedient under the circumstances. And from the unusually rigid condition of the

os I have my doubts whether the Barnes bags would have accomplished the purpose.

It is interesting to note here the effects of the ergot used, which the writer had every opportunity to observe. It seems strange that there should be, at so late a day as this, so much difference of opinion among leading authorities in regard to the use of a remedy whose physiological effects are so well known. One can turn to works of world-wide reputation and find authority for almost any use he may make of ergot. There appeared in the March (1893) number of the *North American* a very interesting and instructive editorial on "Ergot in Obstetrical Practice," which I take the liberty of making some use of.

It seems to be pretty generally accepted that, because of danger to both mother and child, ergot should not be used until after the uterus has been relieved of fetus and placenta, although admitted to be occasionally expedient in the second stage.

Lusk writes: "Of the various internal remedies to stimulate uterine action, ergot should, in the first stage of labor, be unqualifiedly prohibited;" and again, "Ergot should never be exhibited during the first stage of labor, because the tetanic uterine contractions, which it substitutes for the normal rhythmical ones, tend to prevent the further dilatation of the os uteri and to deprive the fetus of its blood supply through the constriction of the uterine vessels." And many other noted writers agree with him.

But other writers who are equal authorities make use of ergot under just these very conditions.

Parvin writes: "Many reputable obstetricians to-day reject the use of ergot during labor, some, indeed, insisting that it should be banished from obstetric practice. It is believed that this is a mistake, and it is unjust to conclude that because there has been gross abuse in the administration of the agent—it has been given in unsuitable cases,

at improper times, or in too great quantities—it should therefore not be used at all”; and Winckel says: “I have recently prescribed the fluid extract in 12-drop doses two or three times daily, even in the first stage of labor”; while one of the most recent investigators, Schatz, says: “The contractions of the uterus, when produced by ergot, in their manner and character do not differ from the normal. Ergot produces properly co-ordinated contractions of the uterus, provided large doses have not been given, and, hence, most probably acts by direct stimulation of the center for uterine contraction”—which statement is a direct contradiction of Lusk.

In the case of which I write the effect of the ergot was to excite perfectly regular contractions, not to be distinguished in any way from the contractions in a normal case of labor, where no interference was necessary.

It is also interesting to note that the ergot had no effect whatever upon the os, in spite of the firm contractions taking place in the body of the uterus, which sustains a statement made by Hughes, and which I have seen nowhere else. In speaking of *caulophyllum* he says: “Its action upon the uterus is like that of *secale*, but with the difference that it influences the cervix as well as the fundus.”

THE NECESSITY OF ORIFICIAL WORK AFTER  
CONFINEMENT.

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BY

H. P. SKILES, M. D.,

CHICAGO, ILL.

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THE philosophy of normal labor is discussed in every text-book on obstetrics, and the danger to the perineum and its immediate repair, pro and con, has been discussed times without number. But there are other points in the progress of labor, either normal or instrumental, which seem to me to be of vital interest to the patient. There are other parts often injured, which cannot be repaired immediately, as can the perineum, which may impair the general system, or any of the particular functions.

We look upon the subject as though the condition of labor was alone in and of the uterus and belonged entirely to that organ, whereas there is not an organ in the maternal body which is not affected by parturition. The liver, heart, kidneys, stomach—in short, there is none that escapes, from the crown of her head to the soles of her feet. From the descent of the fetal head there is danger to the cervix uteri, the perineum, the bladder, and the rectum. When we think of this we do not wonder that many a woman's long and serious illness dates from a severe confinement. Indeed, it may not at the time have been thought severe, and yet have done so much damage that, left unattended to, it has been the ruin of her health. If there is any cause of alarm examine immediately, but if all goes well it is better to defer the examination for two months until the uterus has had time to return to its normal size. In this day of specialties it is impossible for *one* to know all that

pertains to every branch, but it is possible for each one to know enough to realize what should be done.

I recognize the ban that may be cast upon a physician who proposes to examine every mother under his care two months after confinement to discover if any of the parts have been injured, for not only the patient or her friends may think it unnecessary, but there are within the bounds of our beloved profession men who think it not wise to oversee nature until, by paralysis or neurasthenia, by œdema or by pain, or by the stupidity of melancholia or the shrieks of insanity, she calls for help. If I shall be able to impress upon any mind here present that it is our duty to know the condition of the parts involved, and by so doing have the consciousness of preventing a calamity which we may not be able to foresee, I will have accomplished the object of this paper.

I will not detain you with a long history of cases, but will only give the points of a few under my care. Mrs. K., aged thirty-five, had a severe labor January, 1891. Child delivered with instruments; parts not severely injured, but great depression of nervous system, cyanosis of the lips and extremities, great difficulty in breathing, no fever, no hemorrhage.

Fourth day, cyanosis more alarming, depression more pronounced. Patient objected to anything being done, except under the influence of anæsthesia. Chloroform was given, and just at the stage of unconsciousness I dilated the sphincter ani slightly, with some improvement; a little later, a more complete dilatation, and in a few minutes I had the pleasure of seeing that the cyanosis was almost entirely gone. A couple of months later a slight laceration was repaired, and to-day she is a healthy woman.

Early in Autumn of 1893 I was called by telegram to Ohio to see Mrs. S., youngest child six months. Her health had been good until since the last confinement, bowels had been loose ever since, was unable to take much food.

Had wasted to a mere skeleton. Her physicians gave no hope; they had hoped from week to week, knowing her previous good health, that she would rally, but it was of no avail. Examinations showed a severe proctitis; uterus normal.

How high this inflammation extended into the colon we could not tell, but even in the transverse could feel a hardening mass. On a spring cot she was carried to Chicago, and for six weeks she was cared for, washing the entire colon almost every day, but at last the end came, and the autopsy showed an inflammation of the entire colon, excepting the upper six inches. It had extended through the colon and involved the contiguous parts of the omentum.

Microscopical examination showed only acute and chronic inflammation.

If she had received the benefit of orificial methods the first three or four weeks of her illness I have no doubt that we would still have her beautiful life to bless us.

Go with me on the street and watch the crowds as they pass. See that woman of thirty years as she, with extra effort, manages to walk beside her husband.

Take her history: Was well until baby was born; some time after had inability to use one side. She has been treated by electricity, by massage—given remedies, high and low—and has been drugged, and still she keeps her paralysis just the same. It is a puerperal case and might have been relieved.

Go with me to our mad-house, and see the hundreds of mothers who have spent years immured as if they had committed some crime, when no one has committed any crime for which they suffer the penalty inflicted by an unrelenting nature except the ignorant accoucheur.

Go with me to the cemeteries of every town and city in the world and collect the unwritten but oft-rehearsed his-

tory of thousands of mothers who have died prematurely one, two, or three years after baby was born.

Can any take the facts that a few of these cases present—cases living, cases dying, cases dead, and those worse than dead—and tell me that we should not prevent and use every precaution that the human mind can invent to parry these dreadful calamities?

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## OBSTETRICAL SURGERY.

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BY

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NOT infrequently will the obstetrician be called upon to decide between one or another of several operations in order to either effect delivery or to save a child, or both. The saving of the child by any surgical means necessarily involves a certain risk to the mother, and the important question to settle is, which method of procedure, in a given case, is the most promising for *both*.

The old argument of always sacrificing the child in order that the mother may be saved might still carry great weight if it were true that the mother's life was greatly endangered by surgical attempts at rescuing the child. But the argument immediately loses force when we make a comparison of the records between the maternal mortality of embryotomy and Cæsarean section, for instance. It stands as 8 to 6, in favor, it is true, of embryotomy, but to offset this there is a fetal mortality of one hundred per cent. in embryotomy, against only thirteen per cent. in Cæsarean section, which means that if the classical, or Cæsarean, operation is elected two more mothers are sacrificed, but eighty-seven more children are saved out of every hundred.

It is of prime importance that the physician who is to make obstetrics and obstetrical operations a specialty should have clear ideas and positive convictions as to, first, the result he desires to accomplish, and, second, as to the choice of surgical measures to be employed in realizing that end, under any conditions that may arise.

Let us assume a case similar to one that has probably come within the experience of everyone present. In this case labor is due, the pelvis is found to be contracted and distorted, with a conjugate diameter of  $2\frac{3}{4}$  inches, average sized head of living child presenting, the bi-parietal diameters measuring  $3\frac{3}{4}$  inches. Now the question arises. What is to be done? Obviously one of four things: either embryotomy, Cæsarean section, Porro's operation, or symphyseotomy. Before deciding let us describe briefly these very different operations; and by a comparison of their relative values each one may speak for itself as to why it should or should not be preferred above all others.

Embryotomy includes, first, perforation and crushing of the skull—called craniotomy; second, decapitation, which is performed when the shoulder so presents as to make turning impossible; and, thirdly, evisceration, or the evacuation of the chest contents, when in impacted shoulder presentation the neck cannot be reached. These operations all aim to diminish the size of the fetus, or, as in decapitation, to make delivery possible per vaginam. In every case it means death to the child. The maternal mortality of six per cent. is from various causes, principally ruptured uteri and infection.

The Cæsarean, or classical, operation, also called gastro-hysterotomy, or more correctly cœlio-hysterotomy (cœlio = belly), is performed with the idea of saving the child, with a little more risk, possibly, to the mother. It is also performed when embryotomy would be impracticable, as when a living fetus is present. The operation consists in opening the abdomen and uterus through the median line and



extracting the fetus. It was first performed on the dead pregnant woman nearly three thousand years ago, and on the living subject in 1500 A. D. by a sow-gelder, who saved both his wife and child, "after futile attempts at delivery by no less than thirteen midwives and a number of lithotomists." Under the present improved methods the maternal mortality is reduced from fifty per cent. to eight per cent., the fetal mortality being, as before stated, about thirteen per cent.—a much better showing for the child, indeed, than after the comparatively simple performance of version and extraction.

The Porro or Porro-Cæsarean operation (gastro- or cœliohysterectomy) was introduced in 1876 as an improvement on the Cæsarean section in certain cases. In fact, Porro considered it applicable in all cases where Cæsarean section was resorted to, believing it to be safer to remove the uterus rather than to leave the wounded organ behind, there being less danger of hemorrhage and septicæmia. The operation consists in extracting the fetus through the abdomino-uterine incision, as in the "Cæsarean," followed by amputation of the uterus down to the neck. At first the mortality was considerably under that of the classical operation; but since more attention has been given to the technique, chiefly that of stitching the uterine wall, the ratio has changed in favor of the "Cæsarean" as 11 to 8, and the latter is now regarded as the safer operation; but this may be explained on the ground that the "Porro" is the more difficult, involving a greater shock, and is generally resorted to in more desperate and hopeless cases.

Symphiseotomy, although dating back to 1654, was practically abandoned until the year 1866, when Professor Morisani operated on a living woman, saving both mother and child. From that time to the present the profession, especially the conservative surgical branch, has shown an increasing interest in its revival, until to-day it is looked upon as an operation that has come to stay. It has been demonstrated

in the last few years that, with proper precautions, the pubes can be separated  $2\frac{1}{2}$  or even 3 inches, without causing subsequent injury to the patient. Dr. Harris of Philadelphia reports forty-four cases, with a loss of but one woman and five children, the death of the woman being attributed to another cause than that of the operation. Certainly, embryotomy, Cæsarean section, or the Porro operation can claim no such results.

The following is a pretty correct table of comparisons, showing the mortality, both fetal and maternal, for each of the operations during the past eighteen months, not including the fetal deaths occurring during the first week after delivery :

Embryotomy heads the list with one hundred per cent. of fetal deaths.

Porro's operation, second on the list with fourteen per cent. of fetal deaths.

Cæsarean section, third on the list with thirteen per cent of fetal deaths.

Symphyseotomy, last on the list with  $11\frac{1}{3}$  per cent. of fetal deaths.

The maternal mortality for embryotomy is six per cent.

The maternal mortality for Cæsarean section is eight per cent.

The maternal mortality for Porro's operation is eleven per cent.

The maternal mortality for symphyseotomy is  $1\frac{2}{3}$  per cent.

Thus the question of what is to be done in the above-assumed case is answered in unqualified terms. The evidence is so strong in favor of symphyseotomy that comment seems useless. The only other question that concerns us is: What are the general rules for selecting one or the other of the above operations or, in other words, In what particular class of cases may they be said to be strongly indicated? Taking them in order, we will have the indications :

For embryotomy:

1. On the dead child before decomposition or sepsis intervenes.
2. On monsters and hydrocephalic cases.
3. When, after a long tedious labor, with ineffectual attempts at forceps extraction, the child is believed to be dead.

Thus it will be seen that the old practice of indiscriminate and wholesale butchery is narrowed down, and circumscribed by well-defined limits.

For Cæsarean section:

1. Where the conjugate diameter is below  $2\frac{5}{8}$  inches, the fetus being of normal size or larger.
2. In the transversely contracted pelvis of Robert, or the obliquely contracted and distorted pelvis of Nagele.
3. Where obstruction from any cause exists, so that delivery by symphyseotomy is impracticable, or when the indications for the Porro operation are absent.

The indications for the Porro operation are:

1. Where there is evidence of infection to the uterus or to the parturient canal, with the hope of avoiding puerperal complications. (Some go so far as to recommend the operation when infection is feared simply, preferring to be on the safe side, as they put it.)
2. In uterine atony, to prevent *post-partum* hemorrhage and sepsis.
3. In cancer of the cervix, and when large uterine fibroids or myomata are present.
4. When for any reason it is imperative that future conception should be prevented.

Lastly, the indications for symphyseotomy are:

First. When a viable child is present and the operation can be resorted to before the patient has become exhausted, and when it is found by measurement that the antero-posterior diameter at the brim is below 3 to  $3\frac{1}{4}$  inches.

Second. Where there is a conjugata vera not *less* than  $2\frac{5}{8}$  inches, and where there is good evidence that with a pubic separation of, say,  $2\frac{1}{2}$  inches, a living child may be extracted.

Third. When the chin presents posteriorly, and is so jammed down in the pelvic cavity as to render rotation impossible.

As symphyseotomy is at present engaging the attention of so many operators, and interesting even those who never aspire to surgical distinction, it may not be out of place to run over briefly some of the technique necessary to its successful performance, even at the risk of tiring you.

First. Observe the same aseptic precautionary measures as in cœliotomy.

Second. With the patient in the dorsal decubitus, flex and thoroughly abduct the thighs.

Third. Dilate the cervix, unless Nature has already wisely anticipated you, and made such interference unnecessary.

Fourth. Introduce silver catheter, and protect the urethra by depressing it to one side of pubic arch.

Fifth. With scalpel make a vertical incision of about three inches in length over the pubes, beginning about three-fourths of an inch above the symphysis, and extending to, and a little to one side of, the clitoris, dividing skin, fat, and recti muscle attachments.

Sixth. Separate the retro-pubic tissue with the finger, after first protecting the bladder by pushing it back.

Seventh. Pass the left index finger beneath the arch, and hook it round the posterior inferior angle, using it as a guide for the Galbiati falcetta, or the small curved knife of Dr. Harris, or, in the absence of anything better, an ordinary blunt-pointed bistoury, cutting the inter-articular space from within out, and from below up, when the bones will separate spontaneously from an inch to an inch and a half. In case the symphysis be found ossified, a chain saw will have to be substituted for the falcetta or bistoury.

Extreme care in dissection is necessary in order not to wound the urethra or the dorsal branch of the pubic artery, which supplies the clitoris. It passes close to the anterior surface of the horizontal ramus and near the symphysis.

Next, apply the forceps and deliver, having an assistant press and support the ossa innominata during the passage of the fetus. If the uterine contractions are sufficiently strong to effect delivery, of course the forceps are contra-indicated.

Eighth. After removing the placenta unite the adipose tissue and skin with deep and superficial silk sutures; dress with cotton; apply two or three wide strips of rubber adhesive plaster over the trochanters and entirely around the pelvis; bandage tightly the hips, and more loosely the thighs, and put the patient to bed in the horizontal position, and by keeping her absolutely quiet for a period of four weeks perfect union may reasonably be expected.

This operation is the simplest and safest of any we have mentioned, and it is not now, as formerly, regarded as unscientific and dangerous, resulting either in death or in lifelong injuries to the patient. Works on obstetrics a year or two old treat the subject with supreme indifference, some of them (Lusk, for instance) not considering it worthy of mention. Parvin ends his lengthy discourse of four lines and a half with these prophetic words: "The American obstetrician will find no condition justifying its performance, and therefore it is dismissed with this brief reference."

Winckel, in his voluminous work, condescends to give the subject a passing recognition, but is unable to refrain from the expressed hope that the few lines he has given to its consideration may hasten the operation once more to a silent burial, to remain forever entombed.

Notwithstanding these and many other adverse criticisms, the fact remains that many operators are in the field claiming the best of results. These are notably Morisani

of Naples, 22 cases without a failure ; Noble and Harris of Philadelphia, the latter, as stated above, having 44 cases in 6½ years, with a loss of 1 woman and 5 children ; Spinelli, 24 cases, with 24 mothers saved and 22 children ; Chas. Jewett of Brooklyn, who was the first American operator, September 30, 1892 ; Bullezzi of Bologna ; Pinard of Paris ; Leopold of Dresden, and a host of others who have had fewer operations, but relatively as great success.

This paper is offered to this society not with the intention of presenting anything new, nor for the purpose of deciding upon the merits of the operations under consideration, but rather to provoke a liberal discussion, such as will tend to throw more light upon the subject, especially in regard to symphyseotomy, of which Burford of England says: "The relative ease and the absolute efficiency of this operation, its freedom from the risks of Cæsarean section, and its immense superiority over perforation bespeak for it a most brilliant future."

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## THE EVILS ATTENDING THE AMERICAN OPERATION.

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BY

JAMES C. WOOD, M. D.

CLEVELAND, O.

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THE so-called American operation, from an artistic standpoint, is an ideal operation for hemorrhoids. The entire diseased area can be removed ; healthy mucous membrane can be brought down and made to cover the newly created raw surface, whereby the "hemorrhoids" are radically and effectually cured. In the hands of an experienced operator the operation can be quickly done,

and, unless the patient is markedly exhausted, the immediate dangers are not, in my opinion, such as to deter the surgeon from resorting to it. After experimenting with the Whitehead, the clamp and cautery, and the ligature operations, I was, therefore, more than pleased with Dr. Pratt's newer method when he first introduced it. The destruction of the entire pile-bearing inch, when the disease is at all extensive, at once appeals to the surgeon as being in harmony with broad surgical principles, and so it is. But the ultimate test of all surgical procedures must be the results obtained. The American operation should now be weighed in the balance of experience, for it is no longer an innovation; if found wanting, or if the dangers attending its execution are such as to make it wise to cast it aside for more conservative and safer procedures, I for one want to know it. Let me, therefore, at the very beginning, emphasize my position.

I am deeply obligated to Dr. Pratt. I believe that he has done more than any other living man to compel the attention of the profession to the importance of pelvic reflexes, a subject which has long been of deep interest to me. The knowledge I have obtained from the teachings of Dr. Pratt has been invaluable to me. It always requires a man of strong individuality and personality to impress great truths upon the masses. Such qualities are possessed to a large degree by Dr. Pratt. Yet radical teachings by radical men are never attended by unalloyed good, and this is pre-eminently so regarding pelvic lesions. This was true of Emmet's cervical operation, of oöphorectomy, and many other surgical innovations which have now found their level and should no longer be performed with unwarranted frequency. Our surgical friends have corraled the appendix vermiformis, and the first symptom of a colocynth colic is the signal for an appendicular sacrifice. The homeopathic profession has seemingly gone daft over the American operation. Every tyro in surgery is performing it, and

the land is everflowing with its victims. It is for the purpose of calling attention to the evils of the operation, as well as to court a free discussion of the subject, that this short paper is written. If the sequelæ are due to faulty technique much good should come from such discussion.

I need not tell those of you who have often performed the operation that the two complications to be contended against are *incontinence* and *stricture*. I have now performed the operation about fifty times, and I have on my hands from my own list of cases two of stricture and one of incontinence. Besides these, I have had many cases come to me from the hands of other surgeons with the same trouble. I know of one man, the victim of absolute incontinence, who declares he will shoot, on his first opportunity, "the author of his ruin." Some six weeks ago Professor G. J. Jones requested me to see with him a prominent judge in the city of Cleveland who was a terrible sufferer from hemorrhoids. An examination revealed a mass of vascular tumors, as large as a hen's egg, which projected from the anus. It was no uncommon thing for him to saturate his clothing and his chair with blood. I, of course, urged upon him an operation, as the two surgeons who preceded me had also done. His reply was that no less than four of his intimate friends had had the American operation performed on them, and all were left in wretched shape—two having strictures and two incontinence. He, therefore, most politely, but emphatically, declined to have the knife used upon him. I cite this instance to show that the complications mentioned are not uncommon. I know that they are not from personal observation. Nor have the unfortunate cases come to me alone from the hands of novices, for some of them were operated upon by men whose surgical skill and authority are beyond dispute. I have written to many of our best men who advocate, or did advocate, the operation, and nearly all admit that the accidents enumerated are not infrequently met with.



In justice to Dr. Pratt it is but fair that I should state that I have never seen him do the operation. However, Dr. Pratt's written descriptions of it are so explicit and so clear that I have been able to follow—so I am told by those who have seen both of us work—his technique perfectly. I cannot, therefore, attribute my own failures to faulty technique, especially as my experience has not been unique. I have also modified the technique in various ways, yet I have not been able to prevent the slipping of the mucous membrane in a large per cent. of the cases operated upon.

Incontinence is due to two causes: stretching of the sphincters, and the slipping of the mucous membrane. Stricture is due to the slipping of the mucous membrane with subsequent contraction because of the resulting cicatrix. I cannot agree with Dr. Pratt, though I ought not to put my experience alongside of his, that the slipping of the mucous membrane is of slight importance. At least, in the cases observed by me, the raw surface left behind has never become like normal mucous membrane, and there has exuded from it more or less of a discharge. With this condition present there is always a tendency to contraction. The fact is that in the majority of instances where the mucous membrane of the pile-bearing inch is removed, the divided border above cannot be stitched to the peri-anal skin surface without a degree of tension which will almost invariably cause the sutures to cut their way through the mucous tissue. This is especially so if the sphincters are not widely stretched, and undue divulsion is, as we have seen, one of the chief causes of incontinence. This, at least, has been my experience, and I have passed my sutures in every conceivable way. I have used the interrupted and the continuous sutures; I have passed tension sutures high up in the gut with the view of overcoming the tension at the approximated surfaces, and have used the quilted sutures for the same purpose. The quilted sutures have been the most satisfactory of any yet used, yet the

excessive fragility of the rectal mucous membrane will permit them to cut out every now and then. I have resorted to all of the usual expedients recommended as a part of the after-treatment, but the unfortunate sequelæ enumerated have nevertheless occurred.

It is true that a failure of even six per cent. is relatively a very small per cent. of failures. However, in dealing with hemorrhoids we do not have to contend with a condition which is in itself inimical to life. This being so, I believe that we should think twice before resorting to a method which is liable to be followed by stricture or incontinence in even one case out of fifty. Especially is this true if there are other methods which are practically safe, though less radical. At least, in my opinion, the operation should be reserved for extreme cases—those in which the membrane of the lower bowel is so diseased as to be reached in no other way. In this class of cases I presume that I shall every now and then resort to it. However, I believe that the cases calling for so radical a procedure are comparatively few. In women small tumors are readily cured by divulsion and reparation of the pelvic floor. If it is deemed best to remove tumors of medium size they are easily, quickly, and safely removed by catching them in the blades of a strong catch forceps, severing the mass above the grasp of the forceps, then, before the instrument is detached, transfixing the mucous membrane underneath the forceps with a needle armed with a continuous catgut suture, which is to extend the entire length of the blade and back again. The forceps is now detached, the continuous suture tightened with a couple of tenacula, when its two free ends are tied. This will at once be recognized as the modified American operation, except that I use the continuous instead of the interrupted suture, thereby saving much time. If the tumors are large an especial clamp is necessary. By this procedure the mucous membrane is crushed only sufficiently to control the hemorrhage, without inducing slough-

ing of tissue, while the sutures prevent separation of the divided borders during the healing process. This operation can be done quickly, is comparatively bloodless, and gives rise to infinitely less shock than does the original American operation. It is not as artistic as is the American, but, so far, the results in my hands have been entirely satisfactory.

In conclusion: I cannot but feel that the American operation is being performed with a degree of frequency which is bound to bring reproach upon American surgery. It is being done for everything—from fits to freckles. Since, however, it may be the only one suitable in a given case, I especially hope that the various methods of contending against the complications enumerated may be brought out in the discussion.

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## WHY DOES PRIMARY PERINEORRHAPHY SO OFTEN FAIL?

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BY

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NEW YORK.

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**R**EPAIR of the perineum is one of the most important duties connected with the obstetrical art. For reasons practically beyond the power of the obstetrician to control, rupture of the perineum is a frequent accident. It is doubtless true that this accident occurs much more frequently than it ought to do, resulting sometimes from neglectful inattention on the part of the accoucheur and sometimes from overmeddlesomeness. Theoretically the perineum ought to be able to do the work it is called upon to do during labor without serious mishap. But mothers are not infrequently physically far below the standard of per-

fection, and the obstetrical art is not always thoroughly known to the doctor in the case. If it could always be that from the time of conception all through the period of pregnancy the woman could be under the observation of a thoroughly competent physician, the various ills which she suffers at that time could be entirely removed and labor made in due time a purely physiological process.

But before we reach the period when this can be the rule the public must be educated to understand that the doctor's duties begin with pregnancy, and the medical profession itself must be aroused to its true relation to childbearing. This is missionary work which we should all endeavor to do, realizing that it will be many decades before this ideal standard can be realized. As a matter of fact, at the present time the accoucheur very frequently does not see the expectant mother until labor has actually begun, and therefore has to take the case as it is then, and not as it might have been if properly supervised for the previous months. The result is that various accidents occur for which the doctor is not primarily responsible, and among them is more or less serious laceration.

Laceration having occurred, the question at once arises, What shall be done with it? A war of words has long been waged on this topic, but at present there is no universal agreement as to a proper course of procedure. As a rule, those doctors that are more obstetricians than gynecologists incline to the immediate operation. Those who are gynecologists or surgeons rather than obstetricians advocate the secondary operation. A number of articles have appeared in current medical literature of the past two or three years taking very advanced ground against the primary operation. It is not only claimed that the operation cannot, as a rule, be successfully performed and as good results obtained as by secondary perineorrhaphy, but that it is actually criminal to attempt the primary operation.

So widely broadcast have these views been spread that

even the laity have come largely to consider a primary operation as bad practice, and although none of my own families, or patients to whom I have been called accidentally, have rebelled against it, I have known of cases in the practice of my colleagues in which the family was strenuously opposed to the performance of the primary operation, alleging that Professor "So-and-so" had said that it ought never to be attempted. It is because of this sedulous endeavor on the part of our gynecologists, or at least of very many of them, to instill into the public mind the idea that the operation should be deferred for some months, until the woman has fully recovered her strength, and then should be performed *secundem artem*, that I here enter my protest against such doctrine. From a careful observation of a large number of cases in which the operation has and has not been performed as an immediate sequel to delivery, I am very firmly of the belief that the sooner the repair is made after the damage has been done the better.

I recognize how difficult it is, amid the depression both of body and mind on the part of patient and physician in the period immediately succeeding labor, to make a thoroughly good operation, but if the doctor thoroughly understands what he is about to proceed to do he need not really fail to accomplish good results. Although the sooner the operation is performed, if it is to be performed, the better, still the delay of a few hours makes no practical difference. If the delivery has occurred during the night the operation may be made early the next morning, thus allowing both the woman herself and the attending physician a few hours of repose. Or if the delivery has occurred in the forenoon the operation may be delayed until late in the afternoon for the same reason. Equally good results can be obtained six-or eight hours after delivery as they can when the operation is performed at once. I have seen good results even in cases where the operation was delayed a whole twenty-four hours. Still, unless there is some

exigent reason, the delay ought not to be prolonged, and if the condition of the patient will permit, the operation should be performed at once. An advantage which is lost by delay is that immediately after delivery the parts are benumbed and an anæsthetic is not needed.

The apparent cause of failure in the primary operation is that sufficient attention is not given to the vaginal side of the wound. The object of the practitioner seems to be to close up the evident wound and to neglect that which is hidden. But, as a rule, the greater damage is within and not without, and in fact there may be very serious rupture without any appearance of it upon the outside. In making the examination, therefore, at the end of labor ocular inspection is not sufficient. The accoucheur must demonstrate to himself not only that the vaginal wall is intact, but also that the muscular fibers beneath it have not given way. It is not at all unusual for both the cutaneous and mucous surfaces to present a normal appearance, while the muscular tissue contained between them has been badly damaged, and left in such a distended and weakened condition that the perineum can no longer perform its functional duty. To discover this form of laceration requires skill and care, but every accoucheur should endeavor to possess the first and can readily use the other. I think it may be laid down as an invariable rule that repair of the perineum should begin from the inside, and that special care should be used to completely coapt the torn vaginal membrane by a series of stitches beginning at the upper end of the wound and set as closely together as possible, terminating at the commissure. In order to do this properly the patient should be placed in the lithotomy position fronting a good light, and vagina washed out with a calendula lotion and then tamponed so as to keep the parts clean. After the vaginal side of the wound has been thus carefully reunited the exterior, or perineal, side may be brought together with deep stitches, beginning at the anal end of the wound and

passing forward to the commissure. It is well to use cat-gut or silkworm gut for the vaginal side of the wound, and the work is more easily and expeditiously done by means of the uninterrupted suture ; but the external stitches had better be of silk, as these will not melt out quickly, as cat-gut often does. Where the perineum is very thick and the wound deep silver wire may be needed, which has this advantage, that if the tissues swell very much the wire can be easily loosened, while other material commonly used for suturing cannot be. The operation, when completed, should present a smooth and even appearance from both sides, and special attention should be given to make a neat and complete joining at the commissure. One or two separate silkworm gut sutures may be needed here. When the operation is thus carefully performed it will be rare indeed that proper union will fail to be secured. The better progress of the case may be obtained by the use of a weak calendula solution, which not only keeps the vagina clean, but very greatly hastens the reparative process.

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## FECAL RETENTION.

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BY

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THE absorption of poisonous material from the intestine, occurring in cases of obstinate constipation, bears such a close relation to pelvic inflammation and the genesis of disease that a more careful study of this pathological condition is required in these degenerate days. Among the symptoms of fecal retention are urticaria, acne, anæmia, chloasma, flatulent dyspepsia, a furred tongue, foul breath; muddy sclerotics, giddiness, shortness of breath, and palpitation of the heart. In association with a variety of morbid

states deviations are found from the normal character and degree of putrefaction in the contents of the intestine. Facts recently brought to light prove that epileptics suffer excessively from intestinal putrefaction.

The epileptic habit is frequently due to intestinal derangement, especially in children, and when the putrefactive excess has been corrected the seizures disappear. In my experience with epileptics it has been noticed that before an attack the breath became foul, and there was intestinal derangement. In these cases no change of diet had proven satisfactory in correcting putrefactive changes in the intestine.

Constipation undoubtedly tends to the exacerbation of the symptoms of acute mental disease, and neurologists know that the simple exhibition of a purgative will relieve a loaded intestine and bring instantaneous, though often temporary, improvement. There is a mental depression, which should be called visceral. Instead of employing narcotics so frequently, those in charge of insane persons should give more attention to intestinal antisepsis, and not forget the depression accompanying hepatic derangement. A faulty chemical change, especially of proteid substances in the intestinal canal, produces disturbances of the nervous system. A toxæmia from the intestinal canal causes various morbid conditions that cannot be accounted for in any other way. A vicious circle in the vegetative processes of life is established by a faulty condition of the gastric and intestinal juices.

Hysteria, hypochondriasis, recurrent mania, and the various degenerations may originate by the absorption of toxic material from the intestinal tract. The prevalence of constipation among females is a large factor in the production of reflex and sympathetic disturbances. The absorption of hydrogen sulphide ( $H_2S$ ) depresses the nerve centers, as witnessed in attacks of syncope and collapse.

After thorough investigation, the best diagnosticians



have agreed that acute melancholia and chronic Bright's disease are usually associated with fecal retention and intestinal putrefaction. The production of hardened atheromatous arteries, contracted kidney, cirrhotic liver, and sclerosed nervous ~~system~~ is greatly aided by the poisonous and irritating products of abnormal intestinal digestion. Chronic pelvic congestion, due to fecal retention, is the most constant pathological factor among virgins. Habitual constipation causes repeated straining of the folds of Douglas by the passage of large masses of fæces. This mechanical injury develops fissures of the rectum, endometritis, and parametritis. The rectal and peri-rectal tissues are injured by the hardening and subsequent contraction of the para-uterine cellulitis posterior. The return flow of blood from the rectum is obstructed, producing stasis in, and a varicose condition of, the rectal plexus.

Constipation and pelvic disease in women bear to each other a somewhat reciprocal relation. The intestinal canal was not intended as a reservoir for the storage of excrementitious matter, but it is safe to say that more than fifty per cent. of all women make such use of it. In animals of a lower order the first inclination to evacuate the bowels is immediately gratified, and fecal retention is rarely found. Ignorance, indolence, and inconveniences are large factors in the production of constipation in human beings. Habits, occupations, climate, and diet render it almost omnipresent. Phenomena of every degree of intensity and variety may be attributed to it. Any cause which impairs the activity of the voluntary or involuntary muscles employed in the act of defecation will thereby favor the production of constipation. The mechanism which controls the movements of the bowels is very delicately adjusted, and it is no wonder that it gets out of order so often.

The text-books on physiology state that the rectum is usually found empty in a healthy person. In my ex-

perience as a gynecologist I must state that the rectum of a woman is usually filled with fecal matter.

Of course this retention of excrementitious matter is abnormal, and proves that our modern civilization has imposed greater restraints upon women than men, and that the large mass of women neglect the hygiene of the rectum to accommodate a foolish timidity or to obey the dictates of fashion. The viscera in the female pelvis is so disposed that fecal retention is liable to occur on the slightest disturbance of the normal arrangement. The posterior vaginal wall in its middle two-fourths is connected with the rectum, and in its upper fourth with the *cul-de-sac* of Douglas.

Therefore the uterus and the rectum are in close relation with each other, and anything which disturbs the position or surroundings of the uterus will disturb the rectum also. Uterine disorders interfere with the functions of the rectum, and so the almost constant complaint of constipation in gynecological cases is easily explained. Mechanical obstruction of the rectum may occur by pressure external to it. Posterior displacements of the uterus and tumors of this organ or its appendages are examples of such obstruction. Strictures may occlude the rectum, and surrounding effusions may impinge it. The inconvenience, the sepsis, and the pain of fecal retention render the life of the afflicted one miserable. The absence of that sense of relief which a normal movement of the bowels always gives takes out of life one of Nature's greatest comforts, which is worth more to the one who daily enjoys it than silver or gold.

The burden of life is a heavy one at best, and if it is increased by acute pain in the rectum, especially acute with every effort at defecation, and by severe pain at the monthly period, backache, tympanites, indigestion, and many other ills growing out of intestinal putrefaction, one's usefulness in life is arrested, because the burden is too great to bear.

A sedentary life without sufficient out of door exercise, too much or too little to eat at irregular hours, imperfect mastication and insalivation with great haste in eating, and the washing down of food and the dilution of gastric juices by excessive amounts of coffee, tea, beer, milk, water, etc., greatly aid indigestion and constipation. It is the nervous system that suffers most. If the brain and nerves receive no rest the alimentary canal cannot discharge its duties perfectly, and proper secretion of the intestinal juices and efficient peristalsis are impossible.

Self-infection from the intestinal canal occurs not only among sedentary people and those addicted to prolonged mental labor and nervous strain, but among those who are anxious and worried, and especially among women engaged in the duties of household or society.

DR. C. E. SAWYER: In my opinion this is a very important subject, and as such has been most ably handled by my worthy colleague. This class of papers is worthy of encouragement and emulation. They elevate the medical profession to the highest possible standard of excellence, making of us teachers and preventers of diseases rather than dealers in drugs and medicines, the effects of which in many cases are not only questionable, but not infrequently harmful. Success in overcoming Nature's irregularities, manifested by disease, comes pre-eminently to him who looks most carefully after causes and studies most arduously their removal. This paper deals specifically with causes. It teaches physicians the necessity of being on the alert for conditions and not to pass over pathological manifestations as symptoms alone. It also impresses upon them the importance of looking after details and the error of relying upon symptoms alone in lines of treatment to be adopted in any case. It does more than this. It presents for the consideration of the laity the means of overcoming faulty habits, thus relieving physicians of responsibility

that might otherwise be attached to them. It shows the necessity of responding at once to Nature's call, and the certainty with which she deals out the penalty for the breaking of her unwritten laws. American people all like to look well and to be well, and when they have learned that the wrinkles of premature age, the pimpled face, the sallow complexion, the tired feeling, the depressed mental force, the sleepless night, and the general intolerable existence are all dependent upon personal neglect, for which they are individually responsible, one of the greatest stumbling blocks for suffering humanity will have been removed. The only exception to be taken to this paper is that it does not go far enough. It should indicate a successful line of treatment that will overcome the baneful results of fecal retention and consequent absorption. This, to the busy practitioner, is of greatest importance. As a specialist on female and nervous diseases, I have never met a condition that is more difficult of cure than chronic constipation. Like all other cases, invalids afflicted in this way are a law unto themselves, and the only possibility of relief comes through removal of causes. The general symptoms in all such cases are very much alike, but the lines of treatment for their removal are as variable as are the patients themselves. The first and chief object in the overcoming of chronic constipation is the correction of bad habits. All such patients should be instructed to have a regular time at which to evacuate the bowels. This should be imperative whether they have any special desire or not. In many cases it is impossible to reawaken the intestinal peristalsis by any means without having first removed the fecal material found lodged throughout the entire colon. To do this it is my plan to give from 2 to 4 ounces of pure olive oil internally. Then after two hours I have thrown into the colon through an irrigator 4 ounces of pure olive oil, to be followed by an injection of from 2 to 4 quarts of hot water, this to be retained as long as possible, which

is usually but a few moments. The result of this form of treatment is to remove all fecal *débris*, and not unfrequently we find passing away large masses of material which have doubtless been retained within the colon for days, and I doubt not even weeks and months. Most cases of constipation are the result of intestinal atony. The glandular secretions seem to be all right, but the peristaltic action is all wrong. To overcome this condition the most effectual means are those of external manipulation; in other words, abdominal massage. This is best done by another individual, but splendid results are obtainable by personal manipulation. To get the best results from this line of treatment it is advisable to begin the manipulation in the ileo-cæcal region, carrying them up slowly, carefully, and deeply along the ascending colon, over the transverse, and down the descending. This should be repeated from eight to ten times, always following in the direction as above indicated. Following this it is advisable to do the general kneading of the whole abdomen. This should be done thoroughly and continued for from eight to ten minutes. By this time there will be a sense of heat about the abdominal viscera, which indicates the stimulation of the circulation to sufficient degree to ordinarily produce a healthy evacuation. This should be repeated each day at a stated interval until such time as the bowels move freely and thoroughly without it. I do not believe it was ever intended by the Architect of our physical house that the sewer should be so constantly flushed as is recommended by the eminent Dr. Hall of New York. Had that been true Nature would have surely made the necessary arrangements for its execution. I do believe that occasional douchings are effectual, but the best results are only obtainable where oil is used with the water, and should only be repeated sufficiently often to keep the tract from becoming blocked up.

I have not referred to drugs and medicines which may be

of service in the overcoming of this disorder, simply because I take it for granted that every homeopathic practitioner will look carefully into the details of each case to such an extent as to be able to prescribe a homeopathically indicated remedy in each individual case.

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## ● EDITOR'S TABLE. ●

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THE treatment of smallpox by the so-called red-chamber method has been carefully investigated by Dr. W. Oettinger in the Paris hospitals, and is shown to be an efficacious measure for the treatment of the variolic eruption, which, under its influence, develops more rapidly. There is no doubt that in the course of a few days the vesico-pustules of smallpox dry up under the influence of the red light, and that by this means not only is the formation of disfiguring pits avoided, but constitutional derangements are rendered of less frequent occurrence. The philosophy of the value of the red light treatment is that by excluding the violet or ultra-violet rays certain substances, supposed to be toxins, are unable to form or to combine in the interior of the variolic vesicle, and that by this disfigurement of the integument is prevented. It is somewhat singular how near this approaches the mediæval idea that red was the remedy for smallpox. As used two or three centuries ago, the hangings about the bed, the curtains to the windows, and even the dress of the nurse was of red, and the patient himself was enveloped in red bed-clothing. There can be no question that the actinic action of chemical rays by their direct influence upon the skin of the patient is very undesirable, but probably dim light, the bed being sheltered from direct sunlight, will be found just as efficacious as to have the light filter through red glass. Under proper homeopathic treatment there need be no fear of pitting or of sores from the eruption.

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IT is well known that where children live in large groups, as in a school, when a few of them become affected with diphtheria a majority of the children will present a peculiar red appearance

of the tonsils which may be looked upon as a diphtheroid condition. It is, then, not desirable to scatter these children to their homes, because in so doing they may carry the germs of diphtheria into new communities. It has been suggested as a prophylactic measure that the throats of the comparatively healthy children—that is, those in which the disease has not actually developed—should be treated daily with a spray or a gargle of a solution of permanganate of potassium. At all times there should be plenty of fresh air in the schoolrooms and sleeping rooms of the children, but a special effort should be made to keep the air pure when there are epidemics about. The rooms should also be purified daily by burning sulphur in them when they are not in use. This can be easily arranged and the children retained in the school without danger. Whether the permanganate of potassium solution is as reliable as a prophylactic treatment as is lachesis may well be questioned. Not that lachesis is always the prophylactic for diphtheria. Generally the remedy that is suitable to that peculiar epidemic will also be found the prophylactic remedy. The cyanurate of mercury will sometimes be found very useful in this way, but it can only be by careful study of the individual cases that a proper prophylactic can be ascertained in any given epidemic. The duty of the physician in this particular is a very serious one. Many medical men think they have done their whole duty when they cure a fair majority of their cases, but the most important duty of the doctor to his community is to prevent illness, although this may not seem to be to his pecuniary advantage, but that does not make it any less a moral obligation to be first and principally a sanitarian.

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THE subject of juvenile and hereditary epistaxis has been studied by Professor Verneuil, who finds that it has a relation with phthisis. In nearly all cases in which he was able to investigate the family history he found that children suffering from epistaxis were descended from families in which phthisis was a frequent disorder. It has also been noticed that children who are subject to epistaxis are later in life arthritic, and as adults prone to headaches and early obesity. Children subject to epistaxis later in life are apt to develop a tendency to hemorrhage

from other organs, especially the lungs, anus, and uterus, and this hemorrhage may occur even in the absence of any organic lesion. It has also been noticed that persons subject to epistaxis in their earlier years apparently outgrow it at puberty, and then it suddenly returns at about the age of sixty for reasons still unknown.

\* \* \*

THERE is at present a marked tendency to return to the use of natural bread—that is, bread made out of the whole grain. This tendency should be encouraged on dietetic and therapeutic grounds, because bread made in this way contains twice as much a proportion of gluten and of the assimilable phosphates as that found in white bread, while it also contains the laxative fatty matter of the germ which is not found in white bread. Persons who are constipated either by temperament or habit will find great benefit from the use of this natural bread owing to the laxative properties of the wheat oil. The more abundant the meat diet the less necessity there is for the use of a whole white bread, but where the diet is largely vegetable the whole wheat bread furnishes the desirable nitrogenous food. This whole white bread has a distinct pleasing wheaten odor very different from the loaf which is ordinarily sold under the name of Graham bread, which is made of a mixture of bran, rye, and ordinary flour. In a properly made whole wheat flour the bran particles do not show up distinctly. In bread where the bran is evident the flour used is almost certain to be the mixture described above. This has neither the dietetic or hygienic value of the true natural whole wheat flour.

\* \* \*

CERTAIN foreign bodies which are round, and at the same time large enough to fill up the auditory canal, such as peas, coffee beans, glass beads, etc., are sometimes, as every practitioner knows, exceedingly difficult to remove. The effort to extract the object is apt to result in hemorrhage and swelling of the auditory canal, thus wedging in the foreign body still more firmly. Generally a properly directed stream of water from a syringe will displace the foreign body, but it does not always do so. The instillation of warm oil into the ear under these circum-



stances will generally cause the foreign body to be spontaneously expelled. The treatment may be continued for two or three days, when the bean, bead, or whatever the object may be will be found lying near the orifice and can be picked out with the finger. When foreign bodies have got into the ear it is always best to abstain from endeavoring to abstract them by mechanical means. After instillations the auditory canal can be plugged by means of a small tampon, while the patient may be directed to lie as much as possible on the ear into which the foreign body has found its way. The philosophy of this treatment seems to be that the instillations of the warm oil cause contraction of the muscular fibers of the auditory canal, tragus, and anti-tragus, thus causing the spontaneous expulsion of the foreign body.

\* \* \*

THE occurrence of typhoid fever in the villages bordering on the sewerage farms on which are disposed the excreta from Berlin, appears to have been due to the use of the effluent from these fields for drinking purposes. This fact has been investigated by Professor Gerhardt. From this it will be perceived that while the disposal of sewerage in this manner is an advance in sanitation, yet the drainage from such a district must not be used as potable water. In fact drainage water should not be used anywhere except in the open country. In nearly all localities a tube well can be sunk at a comparatively moderate cost considering the value of the water thus obtained. As, for instance, a four-inch well of a depth of three hundred feet, and capable of delivering thirty thousand gallons of water per day, can be put down for about three hundred dollars. This will furnish an abundant water supply for six hundred people free from all danger of drainage contamination.

\* \* \*

ONE important cause, doubtless, of high death rate in diphtheria in the hands of the scientific physician is the influence of fright which, especially in this disease, causes dyspnoea and respiratory spasms. One can readily believe that the little patient who beholds a doctor walking into the room with his face and clothing covered by a white sheet may literally be frightened to death. Other influences besides that of the presence of the over-

zealous scientific practitioner may cause restlessness, and so bring on respiratory spasms. This may be allayed and the intensity of the disease greatly modified by giving from 2 to 5 drops of vinum opii, repeating the dose several times at intervals of an hour if necessary. This is followed by a notable diminution in the cyanosis and drawn condition of the features. Thus laudanum treatment in the majority of cases prevents the need of tracheotomy, and is especially valuable where it is thought desirable to remove the patient to a hospital. A small dose of 3 or 5 drops of laudanum will enable the transfer to be made with safety. It is probable that a careful study of each case would make this treatment unnecessary in any case, but we too frequently see cases *in extremis* when something ameliorative must be done at once, and a moderate dose of laudanum, by removing the present dangerous condition, will give time for more careful study.

\* \*

IT is generally believed that the period of incubation in mumps is tolerably long—from eighteen to twenty days. Dr. Rendu of Paris has observed a number of cases which confirmed this fact. There is a great difference of opinion, however, as regards the period at which the infection is most infectious. The majority of medical men believe that mumps are communicable throughout the whole course of the disease. Some, however, are of the opinion that the contagion is greatest toward the end of the attack, but more careful observation seems to show that the disease is most infectious during the first forty-eight hours. The most highly contagious period would seem to be just at that time when the patient begins to complain of malaise and before the appearance of swelling of the parotids, that is to say, twenty-four hours at least before the disease can be diagnosed. In this it resembles measles. It is now irrefutably proven that measles are in almost every case communicated during the prodromal period, when the patient complains of fever, malaise, etc., and before any signs of eruption have shown themselves. This is important from the point of view of school hygiene. At present children suffering from mumps are not permitted to return to school until three weeks have elapsed after the attack is over. This means a whole month lost as regards school work for

an affection which lasts a week, and which is, as a rule, of no importance whatever. This seems irrational. The enforcement of this rule does not prevent the spread of the disease, since infection takes place at a time when its presence cannot as yet be diagnosed, and children who are well, and no longer capable of communicating the infection, are thus kept idle for three weeks unnecessarily. The quarantine in these cases is absolutely useless and should be abandoned.

\* \* \*

JUST as it is now considered by scientists that all elements of which the world is composed have been developed out of some one original one, of which hydrogen seems to be the least differentiated, so many contagious diseases appear to develop from one common source. Filth is of course at the basis of all contagious disease. A recent communication from Dr. Ricocohon to the *Medical Week* seems to furnish presumptive evidence in favor of the common origin of several cases, which, as far as external appearance is concerned, seem entirely unrelated. The first case was that of a patient seized with acute exacerbation of a varicose ulcer, which developed into a purulent lymphangitis, accompanied by the appearance of a scarlatiniform eruption, and ultimately terminating in pyæmia. A woman who visited the patient in question developed erysipelas of the face, while her husband had an attack of suppurative adenitis of the axillary glands. Moreover, in the immediate neighborhood, a parturient woman was seized with scarlet fever, while a third woman had lymphangitis of the forearm. Lastly, a man who had called on all these patients also had an attack of facial erysipelas. Here it would seem that a woman who had a varicose ulcer was exposed to the scarlatinous *contagium*, an attack of the disease resulting in exacerbation of the condition of the ulcer, and developing into pyæmia. From this case there developed two cases of facial erysipelas, a case of lymphangitis, and another case of scarlet fever.

# THE HOMEOPATHIC JOURNAL OF OBSTETRICS, Gynecology and Pedology.

EDITOR, GEO. W. WINTERBURN, M. D.

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## PUERPERAL DIETETICS.

BY

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PROVIDENCE, R. I.

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IT is a trite saying that experience is the best teacher. Equally true is the less familiar assertion that oftentimes she is a terribly expensive one. When, however, her instruction is in line with recognized natural law, it is augmented in degree and diminished in cost. Well would it be for us, therefore, as a school fully to realize the fact that so long as we shape our labors in harmony with the law of cure, which, like that of gravitation, depends not on human formulation, but on the constitution of matter, success and progress are certain; but when we attempt achievements athwart its course discomfiture and disgrace are inevitable. While, then, there may be a science of dietetics *per se* with broad and fundamental principles, so diverse are the conditions obtained under homeopathic medication

from those accompanying allopathic treatment, other causes remaining identical, that the results of their application in any given pathological condition are well-nigh antipodal. There ought, then, to be, if there is not, a system of homeopathic dietetics. But since parturition is a physiological process, comparatively little distinctive testimony could be educed by the investigation whose results are herewith appended, and yet they may not be without value when considered as merely preliminary to a series of somewhat similar reports I hope to present for a number of succeeding years to another section.

General interest in the matter of administering some light refreshment to a puerpera at an earlier hour than her stomach would crave or could bear food is of comparatively recent date. By refreshments I understand in this connection liquids and solids that tax not appreciably the power of digestion. So completely at variance, however, is the custom of a small proportion of the profession with that of the remainder that I have been compelled, in order accurately to report them, to violate my own classification, but only when absolutely necessitated, and then with vigorous mental protest. I trust this general explanation will remove any subsequent apparent ambiguity or confusion of ideas. All figures are strictly percentage indications of the general habit of our practitioners. When certain physicians mentioned specific articles, they usually enumerated from two to half a dozen, whence the anomaly, quite noticeable in the balance of this paper, of the sum of the parts being considerably greater than the original whole.

Refreshment is given immediately upon the termination of labor by twenty-six, when desired by thirty-one, and when comfortable by three. A few are governed by the clock, one designating fifteen minutes as the proper time, one twenty, three thirty, four an hour, three two hours, and one five hours! Milk is ordered by thirty-four, tea by thirty-one, cold water by twenty-four, beef tea by thirteen,

gruels by nine, coffee by eight, light broths by six, milk and water by five, whisky with egg or milk or water by five ; hot water, malted milk, and stimulants, each by two ; toast water, beef peptonoids, Mellin's Food, grape juice, chocolate, wine, and kumyss, each by one.

The first food given a puerpera by thirty-nine of our practitioners is toast, by thirty-four gruels of various kinds, by thirty-three tea, by twenty-four milk, by seventeen crackers, by thirteen bread, by twelve broths ; coffee and beef tea, each by six ; oatmeal (consistency not stated), liquid food, and farinaceous diet, each by five ; ordinary diet and soft eggs, each by four ; light diet and soups, each by three ; chicken soup, cocoa, grains, steak, and cooked fruit, each by two ; game, beef peptonoids, mush, oysters, lamb chops, semi-solids, malted milk, cracker panada, baked potatoes, milk punch, whisky and egg, and wine, each by one. These articles are administered when desired by forty-one, when rested by three, in one hour by ten, in two hours by seven, in three hours by two, in four hours by one, in five hours by two, in six hours by four, and not until the lapse of twenty-four hours by two. It should be remarked that no relation subsists between the popularly supposed heartiness of anything herein mentioned and the time of its providing.

The food ordinarily supplied to a lying-in patient, previous to the appearance of the breast milk, is said to be toast by thirty and milk by as many, tea by twenty-two, broths by eighteen, gruels by seventeen, oatmeal by thirteen ; a light and plain diet, farinaceous food, and crackers, each by ten ; cereal mush and eggs, each by eight ; coffee, meat, and liquid foods, each by seven ; cooked fruit by six ; light and nourishing diet, ordinary diet, and baked potatoes, each by five ; malted milk, cocoa, and chicken soup, each by three ; oranges, grapes, peptonized milk, and beefsteak juice, each by two ; oysters, fruit, game, rolled wheat, beef tea, bananas, coarse bread, kumyss, Mellin's Food, " tea, toast, and gruel

only," "a liberal diet if spare; if fleshy, scanty," each by one.

On the appearance of the breast milk thirty-nine permit a resumption of the ordinary diet, nineteen make no change (although some of them had not been very liberal in their grants previously), thirteen "increase the amount and the variety of the food," an equal number state they now first give meat, seven allow more solids, five now permit potatoes for the first time; four, vegetables, and as many, eggs; three each order broths, rice, and "bread and butter"; two, chocolate; and individuals, coffee, puddings, cocoa, oatmeal, fruit jellies, soups, essence of beef, fruits, cereals, malted milk, plain diet, toast, tea. One person emphatically says, "No stimulants!"

The minimum date at which the puerpera is authorized to sit up in a chair by her attending physician is reported as five days by one, six days by three, seven days by four, eight days by two, nine days by fourteen, ten days by thirty-two, twelve days by two, fourteen days by twenty-two, and twenty-one days by one. Forty-six find it necessary to make no change at this epoch, twenty-seven first permit ordinary diet, thirteen direct increase of food; two each order steak, eggs, potatoes; single persons provide extra meals, toast, vegetables. Different practitioners forbid respectively eggs, fish, oysters.

Refreshment after dystocia, by which term I mean at this time wearisome labor of any sort, is administered immediately by thirty-three accoucheurs, and when desired by twenty-four. The extent to which homeopathic practitioners are exempt from trying emergencies of every nature can scarcely be realized by those unfamiliar with the consolidated report of the first ten investigations pursued under the auspices of this Institute, to be found in the Transactions of the Homeopathic Medical Society of the State of New York, the *Homeopathic Journal of Obstetrics*, and the *Hahnemannian Monthly* some five years ago.

Therein I pointed out the fact that this is due to the circumstances that they treat for the most part American women, that their system of medication controls conditions entirely beyond the reach of allopathic methods, and that they are more conscientiously devoted to those intrusted to their care than members of the dominant school, which is not the least important consideration.

But to return: Beef tea is selected by twenty-one, hot milk by twenty, tea by nineteen, milk (condition unspecified) by twelve, gruel by eleven, stimulants by eight, and water by as many, coffee by seven, broth by six, and brandy by an equal number; milk punch, malted milk, and wine, each by three; whisky and hot whisky sling, each by two; barley water, Murdock's Liquid Food, milk and egg, Bovine, chicken soup, peptonoids, Hoff's malt, beef juice, lemonade, apollinaris water, kumyss, cocoa, eggnog, and "anything," each by one. Stimulants are emphatically forbidden by one, another permits them when danger from secondary hemorrhage is past, while a third forbids whisky except after hemorrhage.

Food is provided after dystocia immediately by one, when rested by three, when it can be retained by eleven, and when desired by twenty-seven. Others, following the clock, supply it one in half an hour, six in an hour, four in two hours, three in three hours, and one each in four, six, twelve, and twenty-four hours. The articles presented are toast by fourteen, liquid food by thirteen; milk and tea, each by twelve; beef tea, gruels, and broths, each by nine; "light and plain food" and oatmeal, each by five; farinaceous diet and crackers, each by four; "substantial but easily digested" food and bread, each by three; cereals by two; and coffee, cocoa farina, malted milk, solid food, ordinary diet, steak, mutton chops, potatoes, cooked fruits, whisky and egg, milk punch, and wine, each by one. Two prohibit stimulants.

Dystocia occasions no departure from the ordinary



dietary of thirty-three physicians, but fourteen give less solid food, four take care to administer concentrated foods that are easily digested, three add stimulants, two increase the nourishment, while an equal number enforce abstinence until the patient is rested, while individuals order beef tea, Horlick's Food, Ridge's Food, toast, hot milk and water, tea, and "easily digested food."

Post-partum hemorrhage does not modify in any respect the dietary of sixteen doctors. Eleven are prompt to increase the amount of fluids, eight are led to give the food and milk cold, seven think of hot milk, and an equal number of stimulants and of plain milk; five of concentrated food, and as many of a liberal diet; liquid diet, eggs, and beef tea are each ordered by four; an increase and "forced feeding," each by three; stimulating diet, broths, Bovinine, milk punch, and meat extracts, each by two; grape juice, hot coffee and milk, hot salted milk, eggnog, malted milk, digested food, Murdock's Food, albuminous food, malt, peptonoids, hot rum punch, kumyss, rennet custard, oatmeal gruel with milk, whisky hypodermically, "little change," and "stimulants rarely," each by single persons. Two doctors reject stimulants entirely.

In phlegmasia alba dolens twelve direct milk to be given, nine liquid food, five ordinary diet, and an equal number fruits, gruels, and low diet respectively, four fever diet, three broths, and as many nourishing diet, two less meats, and an equal number each no meats, fruit juices, and dry diet, while no milk, no fruit, no starch, Murdock's Food, liberal diet, vegetables, simple diet, bland diet, less liquids, beef tea, bran water, rice water, hot water, gum arabic water, crushed wheat, meat diet, farinaceous foods, vegetable soups, tea, and cocoa find single advocates.

In puerperal mastitis thirteen recommend liquid foods, while twelve direct little fluid shall be used; nine suggest a light diet, and eight a bland diet; six prefer farinaceous food, and an equal number milk: four make no change,

but a corresponding number elect a fever diet ; three avoid meat, but an equal number mention respectively ordinary diet, gruels, and fruits ; vegetables, bread, fruit juices, and grape juices, each find two supporters ; while liberal diet, crackers, potatoes, beef tea, hot water, vegetable soups, tea, and kumyss receive but solitary mention.

In puerperal peritonitis twenty-one recognize the propriety of a general liquid diet, eighteen think highly of milk, six speak well of gruels, four each of a bland diet and of broths, three each of low diet, beef tea, fever diet, farinaceous food, and light diet ; two each of grape juice, oatmeal, milk diet, the white of eggs, toast, and the avoidance of meats ; solitary persons each of chicken broth, liquid peptonoids, fruits, fruit juices, meat juices, vegetables, stimulants, hot water, cocoa, peptonized milk, tea, vegetable soup, milk and egg, kumyss, and Bovinine. Others suggest less meats, little milk, no milk, "neither fat nor salt," and little fluid.

In puerperal cellulitis seventeen adhere strictly to liquid foods, seventeen specify milk as a dependence, five gruels, four each low diet, bland diet, and broths ; three fever diet, and the same number farinaceous food ; two direct us to avoid meat, as many forbid milk, while the same number urge respectively nourishing foods, tea, the white of eggs, milk diet, toast, oatmeal, and malted milk ; single practitioners order no fat nor salt, less meats, baked apples, meat juices, vegetables, fruits, stimulants, little milk, hot milk, hot water, fruit juices, cocoa, peptonized milk, crushed wheat, vegetable soups, Mellin's Food, little fluid, egg and milk, Bovinine, and grape juice.

In puerperal fever (generally so-called) milk is recommended by eighteen, liquid food by seventeen, a low diet by six, gruels by five ; farinaceous foods, beef tea, and bland diet, each by four ; soups, toast, stimulants, tea, and "no meat," each by three ; broths, Bovinine, fruit juices, white of eggs, "good feeding," milk diet, fever diet, oatmeal, and

grape juice, each by two; water, meat juices, "no hearty food," crackers, peptonized milk, baked apple, "little food," hot milk, malted milk, "anything desired," hot water, fruits, vegetables, egg and milk, less meat, crushed wheat, no milk, kumyss, and toast water, each by one.

In "acutest septicæmia" milk still leads with seventeen advocates, while those employing a general liquid diet number sixteen. Stimulants are favored by nine, gruels by five; concentrated food, beef tea, and broths, each by four; little food, light diet, and generous diet, each by three; Bovinine, whisky, fruit juices, white of eggs, milk diet, and farinaceous liquids, each by two; crushed wheat, fruits, toast, vegetables, the avoidance of meat, the disuse of stimulants, soups, sterilized milk, eggnog, champagne, hot water, cream and water, milk punch, nourishing diet, egg and milk, little fluid, meat extracts, mush, and grape juice, each by one.

In conclusion, I must confess that when I came to the tabulation of my returns the difficulty of accurately preserving the practice of each physician presently appalled and then well-nigh overwhelmed me. What I had supposed would be an easy task has proved more severe than those of any half dozen previous years combined. I still have a large mass of returns as yet untabulated, but they will not materially affect the figures above given. I shall present a complete report to the Institute at the earliest opportunity—probably next year.

## CYSTOSPASM.

BY

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THERE is a special functional disorder of the urinary bladder which, during its existence, occupies the undivided attention of the sufferer, and excites more than usual industry and skill upon the part of the medical attendant. This condition is most familiar under the name of irritable bladder, a term as elastic and unsatisfactory as the ready-made hand-me-down malaria. On this account the term cystospasm is to be preferred, as it conveys a definite idea associated with a definite physiological action. The term spasm contains a clear-cut notion of exaggerated muscular contraction entirely independent of the idea of causation.

This derangement may be associated, and generally is associated, with inflammation of the bladder, or the presence of a calculus or a foreign body; but in these cases it is only a concomitant symptom, and does not attain the dignity of a primary condition; it subsides with the cessation of the diseases upon which it depends. Not so with cystospasm as such. We scrutinize the urine and find no pus, no bladder epithelium; we examine again and again—still no pus, no epithelium. Thus a cystitis is positively excluded after a few days' observation. The sound reveals no telltale click of resident stone or sequestered hairpin. Repeated catheterization does not furnish the gratification so frequently solicited by the hysterical patient. On the other hand, the very suggestion of catheterization fills the patient with the most alarming apprehension.

Ocular examination shows the absence both of the rubious caruncle and the aureate drop of gonorrheal infection. The cystoscope throws its rays upon a normal

mucosum. The rectoscope may show a normal rectum, and the colposcope a healthy vagina and cervix. Yet, with all this appearance of healthy organs, the simple function of micturition is accompanied with the agonizing cries of a parturient woman. A sense of weight and uneasiness over the vesical region is predominant. The presence of only a few drops of urine causes the utmost distress, or if the quiescence following a recent neural storm allows a slight accumulation of urine it is soon expelled with all the force of a hydraulic ram.

The persistent efforts of the bladder have a reactionary effect upon the general nervous system. "Tired nature's sweet restorer, balmy sleep," is supplemented by harsh nature's sure destroyer, tempestuous micturition, and the nervous system at last succumbs to a chronic prostration.

My interest in the subject of cystospasm was elicited by a case which was brought to me for treatment. The patient was thirty-five years old. Nervous temperament; facial expression that of a great constant sufferer. Her bed had not been one of roses, for she had slept on a bed-pan for thirteen years. Her sole occupation was to answer the demands of her tyrannical bladder. Every thirty to sixty minutes it required attention; once or twice during the twenty-four hours a horrible paroxysm of pain would rack her poor body for two, three, four hours at a time until life was really not worth the living. During the pain little urine was secreted (that it was not retained was determined by catheterization); the severity of the pain seemed to inhibit the function of the kidneys. The passage of two or three ounces of urine marked the beginning of the termination of the paroxysm. Position seemed to have a causal relationship with the pain: she could not lie down without exciting it; hence her position in bed was nearly upright; her sleep was never more than an hour; her appetite, however, had never failed, consequently her strength was fairly good, though her appearance was anæmic. Menstruation

had been suspended for two years. Examination was made under chloroform owing to the extreme tenderness of the urethra. The canal appeared covered with dilated veins to such an extent that they might very properly be spoken of as urethral hemorrhoids. The vagina was very small, and the uterus seemed infantile in size. The rectum was abnormally red.

Thinking that the bladder trouble might be due to urethral and rectal reflexes, they were thoroughly dilated, with the result of somewhat mitigating the frequency of the bladder spasm. However, the pain was still so great that magnesia phosphoricum was exhibited, but the effect was apparently nothing.

Further study of the case revealed so marked a periodicity of the pain that its similarity to the ague paroxysm suggested itself, and knowing that many nervous phenomena can be abolished if their rhythmical recurrence can be interrupted, I gave 4 grains of cinchonidia sulphate in solution every four hours. The next day the dysuria was gone for the first time in thirteen years; however, in spite of the continued exhibitions of the cinchonidia, it gradually reasserted itself, but the duration of the paroxysm was gradually shortened, and many nights' sleep were received and the patient began to take on weight and improve in color. Two weeks and one-half later dilatation of rectum and urethra was again done under chloroform, furnishing marked relief; then each week for four or five times the urethra was dilated without an anæsthetic, the idea being to anticipate a severe paroxysm and thus to drill the nervous system into better habits. The dilatations were less and less frequently used, till in less than three months the patient was sent home, not cured, but in comparative comfort, and the improvement is still progressing with an occasional use of the sounds.

During the treatment, and after the second dilatation of the rectum, there occurred a prolapse of the rectum with

aggravation of the dysuria. This responded in a marked degree to podophyllum 6th, not only curing the prolapse, but greatly modifying the frequency of urination.

I believe this case to have been a pure neurosis, and that the rectal and urethral congestion was due to the protracted tetany. When the pelvic nerve centers were given a new stimulation through the dilating, followed by a sedation that interrupted their acquired rhythmical activity, the physiological form was established, and the patient was put in the way of recovery. If this explanation is not acceptable, will someone please give a better one?

If this condition be not due to some affection of the pelvic nerve centers, why does it yield to peripheral nerve excitation? Why does it exist in spite of the non-appearance of local lesion? Does it not simulate in many particulars the phenomena familiar to us in epilepsy and tetanus? These are some of the questions stimulated by coming in contact with the somewhat rare condition—cystospasm.

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## A CLINICAL CASE.

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BY

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MRS. S. consulted me about three years ago. Her age was fifty-six, and she was a widow of twelve years. She was married at the age of twenty-two, but never conceived. She passed the menopause ten years previously, and without any severe symptoms relating to that change. As a child she was somewhat neurotic, and for a time suffered from a mild form of chorea. She otherwise had no particular illness in early life. She told me, however, that she had been a most wretched invalid for more than twenty-

five years, and had suffered especially from uterine, nervous, and mental troubles. She had been under treatment much of the time during this long period, and mostly by homeopathic physicians. She had been in the care of specialists, both gynecologists and neurologists, and with all this treatment she had derived only partial and temporary relief. She wished me to make a thorough investigation of her case and help her if possible, but she had little hope of deriving much benefit from treatment.

She presented a perfect picture of despair, and was truly in a very pitiable condition. She was of medium stature, a brunette, and had a fine sensitive nervous organization. She was emaciated, haggard, and mentally distressed. She complained to me especially of a dreadful pruritus vulvæ that she said had been a most prominent symptom with her during her entire invalidism. She said she had scarcely had a good night's rest for years on account of it, and that this almost constant torture, especially at night, robbed her of sleep and appetite, made her exceedingly nervous and quite distracted. In fact, she said that complications of suicide had sometimes been uppermost in her mind, and that her faculties had been so unbalanced at times that she had been considered a fit subject for an insane hospital.

Physical examination gave no evidence of any organic disease of any of the organs of the chest or abdomen, and the uterus and ovaries seemed to be in a normal condition for a lady of her age. The vulva, however, showed signs of some local irritation. There was chronic congestion of the labia, extending to the cutaneous surfaces adjacent, where there was a slight squamous appearance of the cuticle. It was on those affected surfaces that the pruritus existed. Other subjective symptoms noted were sensation of fullness in the head, especially the vertex, sinking sensation in the epigastrium, absence of appetite, a slight sensitiveness in the region of the broad ligaments, and the mental symptoms of melancholia, with suicidal tendencies.



I prescribed *cimicifuga* four times a day, and *lotio hydrargyri nigra* (black wash) to be applied freely to the seat of pruritus. She promised to report in due time, but it was ten months before she did so. She said this long delay was partly because she felt so well that she did not need more treatment, and partly because she desired to wait to see if her good health was permanent before she took the long trip to my office.

She said the first application of the black wash relieved the pruritus, and since the third day of using it she had not felt the least symptom of its returning. With the cessation of the pruritus she began to sleep and eat well, to gain in strength and flesh and lose her nervousness. She gained twenty-six pounds in weight, and enjoyed perfect health for the first time in many years. She has continued well up to the present time, and with no further treatment save an occasional application of the black wash as a precautionary measure.

It is well to pause after the presentation of this clinical case and draw therefrom a firm practical deduction. In the first place, we note the very pernicious effects which sometimes follow with their train of attending symptoms in pruritus vulvæ, resulting finally in a condition of complete invalidism; and how impossible it sometimes seems to be to restore the patient satisfactorily until this local irritation is overcome. I think this symptom is an important factor in causing neurasthenia and its attending conditions much more frequently than is generally supposed. Through feelings of delicacy, or ignorance of the importance of this symptom on the part of the patient, it is sometimes withheld from the knowledge of the physician, when he may grope about blindly and ineffectually in his efforts to restore the patient to health.

This has been my experience in numbers of cases, and I doubt not that some of you can recall similar experience yourselves, where, after more or less prolonged and rather

unsatisfactory treatment, this symptom of pruritus would be prominently presented and then receive especial attention, and in proportion that it could be overcome the general condition of the patient would improve and a satisfactory recovery follow its disappearance.

The properly indicated homeopathic remedy should always be administered, and with this treatment alone many cases of this symptom will satisfactorily recover. There are also many other cases that will not disappear from this treatment alone, which require proper local treatment by the gynecologist. In determining the proper local treatment, each case should be studied individually, a careful discrimination made, and the local treatment should follow the particular indications presented.

We must ever endeavor to remove the cause when it can be ascertained, whatever it may be. The operations of official surgery are often required, and will many times give the most satisfactory results. The removal of uterine or vaginal catarrh, the cure of follicular vulvitis or eczema or many other conditions that may be present, may be imperative to a restoration.

Do not understand from the clinical case I give and its prompt recovery that I present the local use of black wash as a specific application for these cases. There are many very sensitive acute cases that it would aggravate rather than relieve, but there are also many less sensitive cases of long standing, as well as of pruritus ani, that may be promptly relieved and cured by it.

A careful physical examination is often necessary before a proper local application can be well chosen. I will cite a case I had quite recently to illustrate. The patient complained of great pruritus and sensitiveness of the vulva, and I prescribed medicine and gave her washes for some weeks with no particular improvement. I then found on inspection that there existed numerous little aphthous ulcers about the entrance of the vagina, and the patient recovered

promptly from the topical use of a solution of borax and hydrastis.

Many excellent remedies for topical application may be found in our works on gynecology, where they may be studied, and I will not repeat them here. I will, however, mention two remedies that I have never found in any text-books, that I have found invaluable in certain cases. These are an infusion of tabacum and the oil of peppermint diluted with vaseline, glymol, or olive oil.

It is not the purpose of this brief paper to give detailed treatment of pruritus vulvæ, but to simply give a few facts and suggestions based upon clinical experience, and to emphasize the importance of intelligent and concentrated effort to overcome this sometimes exceedingly annoying and most disastrous condition.

Success in treating this would save many a lady from permanent invalidism, a serious form of insanity, a premature death, or a suicide's grave.

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## THE PHYSICAL DECADENCE OF WOMEN AND ITS RESULTS.

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BY

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THE degenerated physical condition of the women of the present age is attributed by some to the higher education, by others to the mode of living, and by others to dress. It is my opinion that all these are factors, but acting only as an aggravation, and not as a cause.

The young women of to-day are performing the functions of womanhood under difficulties due to the ignorance of

women of ages past concerning their own physical nature and its well-being. It was not considered modest for women to know even the rudiments of physiology, and as a consequence they went blindly on, sowing the seeds of untold misery for generations then unborn. They did too much in one line and not enough in another. Their nervous system was cultivated in one direction only, and for lack of a balance wheel there was an explosion of heaped up impulses, this tendency manifesting itself more from one generation to another, and resulting in nervous prostration, hysteria, and insanity. I recently heard a little story that aptly illustrates this point. A man on accompanying his wife to an insane asylum, where she was to be an inmate, was asked what he considered as the cause of her condition. "I am sure I do not know," said he, "any good reason for it. She always lived so quietly at home without any excitement. We have a large family and comfortable home on a large farm. She did the housework, looked after the children, and never went anywhere except to church on Sunday and once in a while to prayer meeting. I cannot understand it, but the ways of the Lord are past finding out."

Another source of physical decadence was the ignorance of the accoucheurs of the past, leaving the women as they did with laceration both cervical and perineal, the idea being that it made the way easier for the next child. In my first years of practice I had a large patronage among the Germans and Bohemians. I can assure you I saw revolting sights. Many with perineal laceration complete of twenty years' standing, and you all know in what a horrible condition such patients are. Others with subinvolution suffering from procidentia, and wearing a sort of a T bandage made from several thicknesses of cloth, thus strapping the organ up so that they could walk. One woman had borne three children suffering in that way. The organ came down after the birth of the first child,

All these women were large, sturdy-looking women, but all suffered more or less from hysteria, irritability, and the usual train of nervous symptoms. One patient informed me that her womb was in her throat, it being a commonly accepted idea that the organ wanders around in the body at will. Taking all this into consideration, is it not plausible that those acquired diseases would have a tendency to weaken the generative organs from one generation to another?

Another cause is the way young girls were reared in the past. They must not play or run like their brothers, because it was not proper. They must knit, do patchwork and fancywork—even at the age of six sew for their dolls, so that they could acquire motherly habits, thus cultivating the nervous system at the expense of the physical. Will this condition continue? Then what will become of the race? Medical science, hygiene, proper physical culture, will help to do a great deal to right the wrong. But Mother Nature has not forgotten her daughters, and she seems to be extending a helping hand to promote the welfare of women in this way.

I have noticed that the women in active life—the clerk, the student, the teacher, the nurse—in a large percentage of cases menstruate at longer intervals. Out of forty teachers that I have treated ten menstruate only two or three times a year, at the same time enjoying perfect health without headache or backache; eighteen menstruate about every six weeks, some of them suffering from dysmenorrhea, but perfectly well aside from that; while the periods of the remaining twelve are too often and too profuse, while they suffer from nervousness, headache, etc. The students are often more or less tardy, and those that menstruate every month are not nearly so well as those that menstruate less often. A number have come to me contemplating marriage, with a history of infrequent menstruation, six of whom I have watched for some time.

One came to me five years ago menstruating only twice a year. I thought then it was all wrong, and applied electricity and tonic treatment, but without result, as she continued to menstruate only semiannually. Since then she has had two children, and remains strong and well. Three others that had menses every three months have each one child. The remaining two are childless. The principal of Grace Hospital training school told me that most of the nurses on entering the active work there, with regular hours, soon cease to have monthly periods, menstruating from two to four times in a year, while they feel perfectly well, many of them improving in health and becoming stronger than they have ever been before.

Aside from these there is hardly a day that I do not hear through my patients of someone who is perfectly well, but menstruates only every three or four months. One of our large dry-goods firms in Detroit employs a great number of lady clerks, among whom I have a large patronage. There are ten, from the ages of twenty to thirty years, menstruating only three or four times a year at regular intervals, exempt from headache, backache, or leucorrhœa.

Taking all this into consideration, and cultivating the women differently from what they have been, I have come to the conclusion that the women of the future will menstruate at longer intervals, and consequently the generation following will be stronger mentally and physically.

## WOMAN'S STEADFAST FRIEND.

BY

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WHEN the chairman of this section requested my services in filling out his appointments, I queried of my innermost soul, What place have I in this coterie of physicians? giants in intellect, in skill, in experience. And then I bethought me that the foremost requisite in making a homeopathic surgeon *par excellence* should be that before all things he be an accomplished physician and expert medicist; otherwise he has no *raison d'être* in homeopathy.

Kept in its proper sphere the skill of the surgeon is entirely admissible; far be it from me to say aught in disparagement of it. No praise can be too high for those proficient in the art who with gentleness and masterly dexterity do all that must be done, and no more, when operation is inevitable. But it should never be forgotten that, at its best, operative surgery is only second best. It can excise morbid tissue, but far better would it be had there been no development of morbid tissue; but it cannot cut out of the organism the tendency to morbid action, yet this is just what the properly selected homeopathic remedy can and does do every day if fairly tested.

Three-score years and more ago our great master told the world: "The application of homeopathic principles appears easy, but is in reality most difficult and irksome; it demands most careful thought and utmost patience, but these find their reward in speedy and permanent recovery of the patient."

With this infallible precept ringing in our ears, with this beacon light ever before us, the homeopathic physician should resolutely set himself to narrow the limits of the

operator's sphere, and the homeopathic surgeon should be the most self-denying surgeon in the world. Let him daily deny himself the brilliant feats of knife and chisel, and substitute the more enduring, though less alluring, achievements of homeopathic medication. Then, and not till then, will woman find in this skillful wielder of steel a friend, tempered and tested to the finest edge—a friend of whom the world can never say: "He was weighed in the balance and found wanting."

When Hahnemann evolved the law of similia, he gave to tired, tried, misused, oftentimes mismanaged woman a host of steadfast friends whose name is legion. From cover to cover of the homeopathic materia medica they await her, individually, in groups, *en masse*. They silently appeal for recognition. But mute will they ever remain unless you and I act as their interpreters to womankind, for they speak in an unknown tongue to the world at large, and the medical world hearkens not to that which they say.

In considering the diseases of woman a golden mean for the practitioner to follow is to carefully consider each and every function of the body, keeping clearly in mind that woman has other organs besides the much-abused uterus and its appendages, and lastly weigh fully and with infinite care the totality of symptoms.

Long-suffering woman has endured the tortures of the damned from unnecessary and harsh local treatment, when a modicum of common sense in matters hygienic and dietetic, united with the correct homeopathic remedy, would raise her from the depths of Hades into realms of perpetual bliss.

The question when to examine a patient depends largely upon concomitant circumstances, and the doctor should exercise a given amount of tact and discretion in the individual case, though, unless the patient strenuously objects, it is well to make a thorough examination in the beginning of every case, even though local treatment be found unnecessary.



Do we as homeopaths fully realize, appreciate, and apply the vantage ground which our remedies give us over all known schools of medicine in the special province of gynecology and in the vast field of obstetrics? that mis-managed area, the fertile source of three-fourths of the gynecological specialist's work? For from what other source do uterine displacements, with their endless train of ills, so frequently come into the specialist's hands as those which follow parturition?

Through all the varying stages of woman's life—from puberty, the milestone which marks the transition from girlhood, to the menopause, when all the vital forces retrograde and die—woman has a steadfast friend (be the affection of the motive sphere or otherwise), from tired, restless, anxious, frightened, ghost-fearing aconitum straight through to forgetful, sullen, easily affronted, lazy zincum if each friend be rightly introduced to the woman in question; for within them “we have a great deal more kindness than is ever spoken,” and they give not forth the sincere, rich communications of their secretest experience save when the keynote is struck by the master hand of the true physician, guided by the spirit of the immortal Hahnemann through all the ages of discord into the sweet harmony which proclaims peace on earth, good will to womankind.

## DYSTOCIA FROM SHORTENED CORD.

BY

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CASE: Mrs. D., a primipara, aged about twenty-five, was taken in labor in the afternoon and called her physician. She was medium in height, stout in build, and the pelvis was ample in its dimensions. She had had a miscarriage some years before, induced on account of severe albuminuria. Was exceedingly anxious to have a living child. Vigorous pains came on apace and soon it was deemed necessary to give chloroform. Consequently I was called in consultation late in the afternoon. Upon examination I found the maternal parts soft and dilatable, the head presenting and in the first position, engaged in the superior strait. There was every prospect of steady progression and a speedy delivery, and the patient was encouraged accordingly. Gradually the pains became fairly tremendous, and it seemed incredible, as I watched the labor, that no progress was being made. While the child was evidently large, the dimensions of the pelvis were so generous that it seemed unlikely that the *statu quo* under such vigorous pains could be wholly due to disproportion. At last I applied the forceps. After traction with each pain the head would markedly recede. I noticed also a rather free discharge of blood after the pains, but thought nothing of it at the time. After at least a half hour's exercise of my best powers at traction the head was brought to the perineum. It was necessary, however, to perform episiotomy to prevent utter ruin of the perineal body, nor was it possible to liberate the head entirely until the cord, wrapped with utmost tension about the neck, was severed. Of course the poor infant was dead—choked to death by

a cruel shortened cord. The child weighed ten pounds and the cord measured twelve inches. Being wound once about an eight-inch neck left only four inches to reach from neck to umbilicus. Then, considering the distance of the neck from the placenta, some idea of the tension put upon the cord and the viselike grasp upon the neck can be formed. Mrs. D., two years later, gave birth to a living son without incident or accident.

I have related this case as a typical illustration of dystocia from shortened cord. Such cases are comparatively rare, and when they do occur a positive diagnosis of the condition cannot be made until the finger can examine the cord or the neck; this may not be possible until the head is entirely or partly extracted, owing to the difficulty of passing the finger beyond the head as it lies impacted in the pelvic canal. It is true that many symptoms are detailed as accompanying dystocia from this cause, but none are differential and may be equally found in other abnormal conditions or even in normal labor. However, the combination of symptoms detailed above ought to arouse suspicion of shortened cord, *i. e.*, retarded descent, especially under vigorous pains and ample pelvic dimensions; marked recession of the presenting part after pains; feeble, irregular fetal heart or total cessation. Hemorrhages after pains, from partial separation of the placenta, may also be present, and possibly severe pains at the fundus or site of the placental attachment. The proper treatment, of course, is to sever the cord and deliver as speedily as possible. But, as said before, unfortunately the cord cannot be reached either to diagnose or sever until the fetus has descended low enough. Alas, by that time it has suffered much; so much, indeed, that fully twenty per cent. die. Mayer (Charpentier) saw 49 out of 685 cases of this kind die, 18 fatal cases of which were due solely to the looping of the cord about the neck. Veit in 442 cases records 63 as apparently stillborn and

7 as dead. It seems to me that a large mortality must always accompany this complication. The mother suffers principally from exhaustion due to the severe and prolonged labor; occasionally from hemorrhage due to placental separation; and, very rarely, from inversion of the uterus.

The cord may be absolutely short, or it may be shortened by looping about some extremity, the trunk or the neck. An absolutely short cord is undoubtedly very rare. The above, 12 inches, is the shortest I have seen; probably if it had not been wound about the neck it would have permitted a safe delivery. Charpentier says his shortest was 11.2 inches. But others much shorter have been recorded; Sclafer had one hardly a half inch long; Malgaigne, 2.7 inches; Meissner, Reale, 4.5 inches; Depaul, 4.8 inches; while Mason Good, Stute, Mme. Danthez, and Thouret have recorded cases in which the cord was entirely wanting. *Per contra*, it is interesting to know that Churchill had a cord 88 inches long and Schneider one 120 inches long!

Shortening due to looping of the cord is much more common and it is even more dangerous than the absolutely short cord; for here we have added the destructive effects upon the fetus by compression of the neck, congestion of the brain, and total stoppage of the circulation in the cord. Looping about the neck is far more frequent than about other portions of the body. It is very common to find the cord wound once or twice about the neck. An average cord is 20 inches long. We can see that one or two loops about a 6 or 8-inch neck will leave nothing to spare, and it often requires the utmost haste to slip the loops over the head as soon as it is expelled and thus prevent asphyxia. The highest number of loops in my experience has been 5. Chantreuil, Rouze, Baily, and Campbell have seen 6, Bandelocque 7, and Mme. Waldwogel 8. (Charpentier.)

## THE PARALYSES OF DIPHTHERIA.

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BY

O. EDWARD JANNEY, M. D.,

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THE fact that diphtheria causes, usually as a sequel, a peculiar form of paralysis is now recognized. Attention has been called to this phenomenon at various times since Nicholas Lepois referred to it in 1580, but the medical mind has been loath to accept a fact so apparently strange.

About twelve per cent. of those who recover from an attack of diphtheria suffer from paralysis. It is observed after the false membrane begins to disappear, or more frequently after the active symptoms of the disease have entirely departed, and the patient is in a state of convalescence. Instances have been observed also in which paralysis took place during the first days of the attack.

Both sensory and motor nerves are affected, and atrophy rapidly takes place if the paralysis continues sufficiently long.

*Loss of tendon reflexes.*—The earliest paralytic phenomenon that occurs is the loss of tendon reflexes. What is known as "knee jerk" is absent in about one-half of all cases of diphtheria, this symptom being observed often as early as the first day of the attack. It is apt to continue for a considerable period, and outlasts the other symptoms.

*Palatal paralysis.*—Paralysis of the velum palati and the muscles of the fauces is the most common form that is caused by diphtheria. In severe cases the palato-glossus and the pharyngeal constrictor muscles become paralyzed. Its presence is recognized by slowness of speech, nasal tone of voice, snoring during sleep, and difficult deglutition, with a return of fluids through the nose. In severe cases, the muscles of deglutition being all paralyzed, swallowing can

only be performed by throwing the head back and allowing fluids to descend the esophagus by gravity. Liquids flow outward through the nose, because the passage way to the nose is not closed by the soft palate as is usual. Sometimes the epiglottis is affected, and the opening to the larynx not being closed, food enters, causing spasmodic coughing.

After a week or two this form of paralysis usually disappears, the muscles regaining their wonted power, but it continues longer in many cases, especially in those in which blood poisoning has been marked.

*Multiple paralysis.*—Multiple paralysis also occurs. This generally begins as palatal paralysis, but not always. In this variety the patient loses the use of many groups of muscles, although not all in the same degree. Thus the use of the lower limbs may be lost, while that of the upper extremities is retained. Paralysis of all the muscles of the body never occurs, and the degree of power or sensibility lost in each group of muscles may vary from day to day. "The numbness, for example, which the patient has been experiencing in one leg will suddenly cease, and become greater in the other leg. To-day the right hand will not give a dynamometric pressure of more than ten or twelve kilograms, and to-morrow its power will have augmented, while that of the left will have diminished; then the parts which were first affected are a second time attacked, and become more affected." (Trousseau.)

Impairment or loss of vision is often a part of this form of paralysis; the limbs also become weak and unable to support the body; objects cannot be picked up or even held in the hands; and this impairment of muscular power may continue until the patient becomes entirely helpless. In those muscles in which motion is interfered with sensibility is generally lost with numbness.

Multiple paralysis may last for weeks or even months. Power usually soon returns to small muscles, but comes

back more slowly to larger groups. In the course of time, however, full power generally returns.

*Paralysis of the heart.*—In every case of diphtheria there is danger of heart failure. Usually, but not always, this occurs when palatal paralysis is already present. The attack is sudden in its onset. The skin becomes pallid, perhaps cyanotic; respiration is embarrassed; the patient may show distress or pain by cries; vomiting may occur; the pulse is found to be very feeble and abnormally slow, soon increasing to great rapidity (160), and then disappearing. While death almost always follows these symptoms immediately, life is occasionally slightly prolonged. Active stimulation at the moment that *slowing* of the pulse occurs has saved life, but prompt action is required.

The cause of heart failure in diphtheria is not easy to determine. In some cases the heart has become weakened by the fatty degeneration of its muscle fibers. "When the general disease lasts long and is very intense, and especially in cases in which death is caused suddenly by paralysis of the heart, the muscle appears pale, soft, friable, broken by extravasations of blood, and on microscopical examination most of its fibers are seen to be already in an advanced stage of fatty degeneration." (Oertel.)

Such a condition of the heart muscle might in time weaken the organ beyond recuperation, yet the heart failure is too sudden in the class of cases under consideration to assign it to this cause alone. Again, death has occurred from sudden stoppage of the heart when the autopsy revealed the muscle to be in a normal condition.

Others have argued that death is caused by thrombosis, blood clots being generally found in the heart cavities. It has been shown, however, that those clots do not differ from those found in the heart after death from other causes, and that they are probably formed *post mortem*.

When the suddenness of heart failure in diphtheria is taken into account, together with the presence of paralysis

of various other muscles of the body, we are led toward the belief that the phenomenon of heart failure is caused by paralysis, due to some influence on the nerve centers, which reaches the heart through the pneumogastric nerve. This would account also for the concomitant symptoms, *i. e.*, vomiting, epigastric pain, and dyspnœa, observed in cases of heart weakness, and offers the best explanation of the unfortunate accident.

What is the underlying cause of the paralysis, four forms of which have been described as occurring in diphtheria?

Investigations conducted with the aid of the microscope have ascertained that lesions of the peripheral nerves exist, and that congestion and degeneration of the gray matter in the spinal cord and the brain occur. But we have not yet reached the cause; these are effects of disease, or symptoms of disease, just as the false membrane and the general debility are symptoms. These changes in the nerves are probably the cause of the paralysis, or they, at least, prolong its course and make it more serious in character, but there must be a cause to explain why the nervous system is thus affected.

Trousseau, who came to his conclusion without the aid of the microscope, concludes that "the real cause is the poisoning of the system by the morbid principle which generates the malady, on which the paralysis depends, and in regard to the mode of action of which in producing the paralysis we shall always perhaps remain in ignorance."

Microscopy and chemistry, however, have combined of late to throw light on this subject, and recent investigations indicate that the true underlying cause of the paralysis is the absorption into the nervous system of a poisonous substance (toxalbumin)—a ptomaine—formed under the pseudo-membrane by the action of bacilli upon the albumin of the tissues.

Just how the different forms of paralysis are produced by this poison must be determined by future investigation.



## THE DUTY OF THE PHYSICIAN IN THE MANAGEMENT OF THE ACUTE PULMONARY DISEASES OF CHILDREN.

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BY

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I DESIRE that this brief paper shall be considered more in the nature of an interrogatory than as representative of an opinion of my own upon a class of disorders whose importance is emphasized by their frequent occurrence and the suffering that follows the destruction of the integrity of the important organs involved.

I have no doubt but that many members of the association present have given careful consideration to this subject and have well-defined opinions thereon; and it is for their valued advice, elicited through discussion, that I offer this topic for their deliberation.

I do not desire that the class of cases referred to in the title of this paper shall be considered as occurring in very young children, but more particularly in those between the ages of six years and sixteen; and by way of illustration I shall specify the one most frequently encountered, viz., croupous pneumonia.

I have believed it wholly unnecessary to make any attempt at a contribution to the medicinal treatment of the disease, as I think our present methods give such excellent results as merit expressions of satisfaction therewith; but shall rather direct my composition to the inquiry, whether the physician's duty is done and his supervision of the case at an end when, with other indications of recovery, the temperature and pulse rate have fallen to normal.

I do not believe I underestimate the seriousness of a

given case of the disease in question when I venture the opinion that during the period of pyrexia, lasting perhaps not more than ten days, both the gravity of the case and the responsibility of the physician are much less than during the ninety days immediately following.

In many instances have we all read the detailed reports of cases of pneumonia, extending from the time of the initial chill through the succeeding week or more of febrile action, stating precisely the morning and evening record of temperature; the character and color of the expectoration; locating exactly the lobar site of the exudation; and finally, after giving the names and perhaps potency of the medicines used, closing the report by the important statement, Discharged cured. Is there a member present who believes such a report true?

What thoughtful physician would entertain the idea of dismissing from observation a patient suffering with acute parenchymatous nephritis upon the disappearance of the general symptoms of excited circulation? And yet, why not discharge the latter as well as the former? Is there greater peril in the partially occluded tubuli than in the equally impermeable alveoli?

Again, what careful oculist or aurist would think of discharging as cured a sufferer from an inflamed cornea, or a hypertrophied tympanum, because the improved vision and lessened photophobia in the one, and the disappearance of distressing tinnitus of the other, betokened a marked amelioration of the patient's condition?

Or what solicitous gynecologist would pronounce recovered a patient who had suffered an attack of pelvic peritonitis, but who, although her temperature and pulse were normal and her local pain but slight, has a uterus as immovable as the bony walls of the cavity in which it is anchored?

If it is, then, such an important matter in the case of the gynecologist and others, and so essential to the well-

being of the patient's future that she be kept under observation until the removal of the products of inflammation has been accomplished, is it not of equal concern that the physician, who has been the patient's skillful pilot through an acute pneumonitis, should not relax his endeavors or relinquish his responsibility until he has succeeded in accomplishing, as completely as possible, the removal of the exudate from the alveoli and their communicating branchioles? Will he not by so doing deserve at least as much of the patient's gratitude as for his close attention during the first fortnight of his illness?

That there is a necessity for such subsequent care and treatment as I have suggested I believe I have had many evidences; and to take brief notice of one will serve to describe all:

A child of ten years had acute croupous pneumonia some three years ago; she apparently recovered. But recently the development of slight rigors each morning, a dry cough and nocturnal perspiration, invited an examination, which disclosed the fact that within the same lung previously diseased, and in the identical location of that infiltration, is found the undoubted evidence of solidification, that can have no other cause than the attack of years ago.

If this conclusion is correct, what a fruitful source of chronic disease each case of acute inflammation surely is, and how necessary that the physician should so direct its management as to secure the complete removal of its products and the return of the organ to its normal state.

## UNUSUAL CAUSES OF ASCITES.

BY

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THREE infrequent causes of ascites having come under my observation during the past two years, I am tempted to present them to this section. I claim one (the last) as unique and the other two as unusual. The common causes of ascites are cardiac, renal, or hepatic disease; malignant or tubercular infection of the peritoneum or omentum; subacute idiopathic inflammation of the peritoneum or venous engorgement caused by tumor pressure. In neither of the cases reported did any of these conditions exist. The simple presence of a small benign growth, different in each case, was the provoking cause of the enormous effusion, and the removal of the growth gave immediate and permanent relief. In each case the peritoneum was found smooth, rather pale, and free from any evidence of present or previous inflammation.

The first case is an American woman, fifty-two years of age, who came into my private hospital with the following history: Ten years previously she had all the physical signs of an ovarian cyst. She grew as large as a woman at full term, and then, during some slight exertion, she felt something give way within the abdomen, and during the next few days the enlargement of the abdomen disappeared, the kidneys having acted very freely. Within a few months of this time she commenced again to enlarge, but this enlargement was due to fluid loosely contained in the abdomen. When the ascites became so great as to make her decidedly uncomfortable she was tapped and about forty pounds of high-colored fluid taken away from her. This was repeated three times. I saw her soon after the last

tapping. Upon careful examination I found a small, soft, flat mass in the right inguinal region, and believed it to be the remains of a ruptured ovarian cyst and as such the cause of her ascites. I advised a laparotomy. This was done, and the macerated remains of the ovarian cyst were removed. It was small, not more than an inch and a half in thickness and four or five inches in diameter. The woman made a quick and uneventful recovery and has remained cured of her ascites. The question arises in this case whether the accumulation of fluid in the abdomen was due to secretion from the peritoneum on account of the irritation of this foreign body, or whether it came directly from the inner surface of this ruptured cyst. There are cases on record where the ruptured cysts continue to secrete their peculiar fluid.

The second case came into my hospital with this history: A German woman, forty-two years of age, mother of several children. Fifteen months before I saw her she was supposed to be pregnant. The abdomen enlarged, but somewhat more rapidly than normal, and finally became enormously distended. The idea of pregnancy was abandoned and I was called to see the case. I found the abdomen enormously distended with a loose fluid. The walls were thinned out and attenuated so that there seemed to be hardly any muscular structure left. The pouch of Douglas was forced out at the vulva and contained probably a pint of water. A careful palpation and ballottement discovered a small hard tumor in the left inguinal region, not falling low in the pelvis. A laparotomy was decided upon. After the fluid was emptied a small fibroid tumor of the left ovary was discovered and removed. This tumor was just beginning to show cystic degeneration. It weighed about two pounds. In this case the presence of a benign tumor of the ovary, small in size, was sufficient to cause an immense accumulation of ascitic fluid in the abdomen. There are other cases on record where fibroids of the ovary have been

attended by ascitic accumulations. Why a small fibroid of the *ovary* should be thus attended, when both large and small fibroids of the *uterus* are invariably free from ascitic accumulations, is an interesting question. This woman made a perfect recovery and has been entirely cured of her ascites.

The third case came to the Chicago Homeopathic College Hospital under my service. A young Irish girl, nineteen years of age, presented herself with this history: She had never menstruated. Two and a half years previously she commenced to have some enlargement of the abdomen. After some months this was diagnosticated as ascites, and she was tapped and about twenty-four pounds of clear ascitic fluid drawn from her. From that time until the time she came into the hospital, a period of a little less than  $2\frac{1}{2}$  years, she was tapped more than 120 times, and the enormous quantity of 3160 pounds of water was taken from her abdomen. For several months she had to be tapped as often as every five days. Physical examination showed an enlarged, tense abdomen with loose fluid. Digital examination revealed a small firm tumor lying rather low in the pelvis and a little to the left. It was also discovered that the uterus was rudimentary, not exceeding a Lima bean in size, and that in all probability there were no ovaries. Examination of the chest revealed no mammary glands. The external organs of generation were fairly well developed. The diagnosis was fibroid tumor, springing from some unknown tissue, in the pelvis. Laparotomy was done, the fibroid was found, but instead of being of pelvic origin it was attached to the parietal peritoneum after perforating the omentum a little to the left and below the umbilicus. Inspection of the pelvis showed a rudimentary uterus not larger than a Lima bean, and no ovaries. Bladder was greatly misplaced, and its fundus cut open to the extent of two inches in making the original incision. This patient

made a rapid and perfect recovery and was cured of her ascites. I claim this as a unique case as regards the amount of ascitic fluid drawn out, the peculiarities of development, the peculiar location of the fibroid, and its influence upon the peritoneum. A small, smooth, benign tumor attached to the parietal peritoneum gave rise to the greatest accumulation of fluid ever reported as being taken from any abdomen.

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THE IMPORTANCE OF MORE THOROUGH  
AFTER-CARE OF THE PARTURIENT  
WOMAN.

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BY

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I SEEM to have selected a very long title for a very small paper, but the subject is an important one.

It was suggested to me as a fruitful theme by a wise and conscientious physician who has had a long and successful obstetric experience.

Then, too, the importance of the subject was impressed upon me recently by a patient who, though several years married, has never conceived. She gave as her reason for this that she had always been delicate, and did not wish to break herself wholly down by giving birth to children. To convince me of her superior wisdom she said: "On looking around among all the mothers of my acquaintance, many of whom I knew as robust girls, there is not one who is not faded, broken down, or a confirmed invalid."

I assured her that I knew many mothers who had reared even old-fashioned families, and besides had accomplished much good for humanity in general, that were still in fine physical and mental condition.

I further tried to make clear to her that childbearing was a natural and physiological process, and that when women suffered afterward it was usually the result of the transgression of simple hygienic laws, but might be due to the lack of common sense on the part of the patient, or the lack of after-care on the part of her physician.

However, it is a lamentable fact, proved by numerous cases in our notebooks, that a large percentage of the ailing women who come to us for treatment date their bad health from "a poor getting up" after childbirth. Especially do we find this to be the case with women who have had abortions either accidental or produced.

So it is for these reasons that I write upon this subject, and not that I have an especial grudge against the good-looking groups of men whose faces have adorned the frontispiece of recent issues of the *Medical Century*.

It is not that I wish to take from these eminent gynecologists any legitimate practice. On the contrary, I have a laudable ambition that they should do more and better work than do the surgeons of any other school.

But to repeat what we all so well know, and what has been affirmed again and again: when obstetricians do their work better there will be less of a certain kind of work for gynecologists to do.

In truth, one of the greatest evils from which the parturient woman suffers by the neglect of her physician does not come within the province of the gynecologist. This is the mammary abscess, the suffering of which exceeds beyond all comparison the pains of labor.

Many physicians of my acquaintance leave the entire care of the breasts to ignorant, untaught nurses, not even making an effort to relieve the engorged or "caked" glands when notified that such a condition exists. They simply do the lancing, after the nurses have worked faithfully and applied various greasy, dirty-looking applications in the vain hope of aborting the dreaded abscess, or "ris-



ing," as it is always called. Could a name be more appropriate?

I find it to be the exception in my vicinity for a woman *not* to have had trouble with her breasts. One who had given birth to eleven children told me her breasts "rose" after every labor, and so familiar did she become with this condition that she borrowed a lancet and opened the abscess herself! Yet some there are who persist in saying that women have "no nerve," and that they never can make surgeons.

One case that made a lasting impression upon me in the earlier days of my practice, and to which I referred in a paper read before our Southern Association, was that of a primipara who was attended by a doctor of the old school in fairly good standing in the profession. He did not make his "party call" until three days after labor, when he was sent for. There was some trouble with the nipples; the baby either refused to nurse or the pain of the suckling could not be tolerated. At any rate, the inevitable mammary abscesses resulted. The breasts were lanced again and again, suppuration keeping up until the entire glands had disappeared. When I saw the patient, three months after labor, there was not a vestige of either mamma. With the exception of a few scars, there was flatness and smoothness of the entire chest.

I had been taught that it was the doctor's fault if his lying-in patients suffered from mastitis, and that it was his duty to examine the breasts at every visit, not trusting to the reports of the nurse. This I had always done, and had rather prided myself on the fact of never having had a case of mammary abscess in my own practice, although I have cared for a good many coming from the hands of other doctors. Indeed, I intimated rather plainly that such cases need not occur in the practice of any painstaking physician, especially not if he were a disciple of Hahnemann.

It has been wisely said that "pride goeth before destruction and a haughty spirit before a fall," so I have since had the unpleasant experience of a bad case of glandular mastitis in one of my own patients.

I usually watch my parturient patients carefully, and make many more visits than is customary in my part of the country, but in this instance the nurse had been dismissed on the tenth day, and as all had gone well with the healthy mother, whom I had cared for in a previous confinement, I gave the case no farther thought. On receiving word that one breast was "caked" I sent remedies with directions that the gland should be emptied; but this was not done. A tender nipple—the usual cause—was the excuse for not allowing the baby to nurse; the breast pump did not do the work; the old colored auntie, who had been recalled, did not carry out my directions for softening the gland, but resorted to her own poultices instead. The result was weeks of suffering, the greatest ever experienced by this most patient patient, who could ill afford the time from the cares of her little family to be sick. The lesson has not been lost upon me, for I thereupon resolved that I would not in future lose sight of my patients even at the tenth day; neither will I, however busy, again trust to the manipulations of an ignorant nurse to remove milk from the obstructed ducts.

If the infant is not given "teas" or any artificial food, but is taught to nurse not too frequently and with regularity, it is conducive not only to the peace and comfort of both mother and child, but is also an important factor in the prevention of mastitis.

I do not have the trouble, doubtless encountered by some doctors with a more fashionable clientele, of having mothers refuse to suckle their babes, for other than unavoidable causes. The greatest difficulty I find is in getting mothers to *stop* nursing their babies when they are old enough to be weaned and after the menses have returned, thus overtaxing

the mother and doing a positive injustice to her child. We are all familiar with the true reason for this prolonged nursing; but some give as the reason fear of bowel troubles, incident to the second summer, while others wish to continue the nursing until all the teeth have come through.

If we could spare a little time to teach these mothers that this drain upon themselves is seriously injurious both to themselves and to their offspring, and help them to find a suitable food to take the place of the breast milk, it would come under the head of *very good* after-care.

I need not dwell at length on the importance of the repair of a lacerated perineum as one of the most important measures in the after-care of the parturient woman. I think but few physicians now advocate leaving the repair of a bad laceration to nature, or deny the importance of an entire or restored perineum in preventing that "let-down" feeling complained of by so many patients. Whether the operation shall be primary or deferred to "a more convenient season" each obstetrician must decide for himself, according to the condition of the patient, the needs of the case, the help to be obtained, etc.

No one can complain of a lack of "light" on this subject, even though the "lack of illumination" proves a bar to the immediate operation, for the subject has been ably and fully discussed in our medical journals.

The bulk of surgical opinion seems to favor the immediate operation; but, on the other hand, many good and sensible reasons are given for the secondary operation.

Some of the bolder operators are advocating an immediate repair of cervical tears as well; but my judgment would counsel the deferring of this operation until after the weaning of the child; I am sure nature heals many slight rents in the cervix. And just here let me ask why it is that surgeons who forbid the giving of vaginal douches after a trachelorrhaphy, lest the office of nature's kindly lymph be interfered with, will advise the giving of antiseptic washes

after labor while there is a possibility of nature's doing all the work?

I no longer give the douches, except for cause, as fetid lochia, rise in temperature, etc., until from three to five days after labor, when I follow the cleansing wash of simple boiled water with another containing *hydrastis*, *calendula*, or *hamamelis*—the latter if the sanguineous flow keeps up.

A light and mostly liquid diet I consider of great importance in promoting the well-being of the lying-in woman, and in preventing the rise of temperature about the time the milk comes.

Oatmeal gruel is a favorite diet with which to promote the flow of milk. I allow fruits, such as oranges, prunes, baked apples, bread and butter, or toast, milk, soft-boiled eggs, and tea or coffee if the patient has accustomed herself to the use of these beverages. Where the cereals are relished I like my patients to have the entire wheat in some form.

If more milk comes to the breasts than the infant can dispose of, I counsel the reducing of even this mild fare.

I am aware that in advocating a light diet I am running counter to the opinion of some medical men high in authority, who recommend a generous feeding of meats and other strong foods after labor, but my own experience is that the entire system needs rest at such a time, and that the woman's digestive organs will be in much better condition to assimilate food when she gets about if not taxed to their utmost during the lying-in period. Common sense should teach that where a person is confined to the bed or the house from any slight indisposition he would not require the same quantity or quality of food that could be digested under normal conditions and while exercising in the open air.

Then, too, a cooling and relaxing diet will conduce to a more free and natural action of the bowels. A free movement of the bowels should be secured before labor, and

again by the third day after labor. What may seem an unimportant matter will prove a greater annoyance to some women than a more grave complication.

When the bowels do not act naturally or from remedies given, a copious draught of citrate of magnesia or an enema or both will have the desired effect.

A too early getting up after labor is, in my opinion, the cause of much suffering to many women. While we all know some robust ones, especially in the lower walks of life, who, like the traditional Indian woman, take but a short time to recuperate from the effects of labor and seem none the worse for it, we can also recall many cases of impaired health from a too early getting up, and from resuming household duties before the involution of the uterus can have been completed.

When patients can afford the luxury of rest, and in every case where it is possible to remain quiet for three or four weeks after labor, I advise that it shall be done, and am sure they are in better condition for it when they do get up.

In cases of miscarriage I think much of the after suffering comes from not realizing the importance of remaining quiet the proper length of time. Some women do not go to bed and others but for a few days, thinking an early abortion but a small matter.

When I am so unfortunate as to have a case of this kind in my practice I give the patient better care than if she had gone to term, and insist that she shall remain quiet just as long.

One measure which will prove of benefit to the overworked mother (or to any mother, for that matter), if she must resume her household duties while her uterus is still in a state of subinvolution, is the removal of the stiff corset and the wearing in its stead one of the health waists suspended from the shoulders buttoned in front, and with buttons for the attachment of all the clothing. If this is too much trouble to arrange, a pair of ladies' suspenders

can be purchased for a quarter, or shoulder straps be made to which all the skirts can be pinned.

Only those women who have tried this manner of dressing are able to appreciate the comfort it gives.

Perhaps the title of my paper should have been "The Importance of More Thorough Care of the Parturient Woman before and after Labor," as some of the ills I have referred to are in great measure preventable.

To prevent mastitis is, I am sure, more commendable than the utmost skill in opening the abscess.

This "ounce of prevention" should begin with the care of the mammæ and the nipples months previous to labor. Especially is this important in the case of primiparæ.

To prevent a laceration of the perineum is even better than the most scientific operation for its repair. That this can be accomplished in many cases, even of aged primiparæ, I can testify by experience. Much can be done to relax by the use of the warm sitz bath both during the last weeks of pregnancy and during the first stage of labor. I have given as many as three or four of these hip baths during a prolonged or dry labor, and have found where a woman has had these baths during one labor she will ask for them the next time. Warm vaseline or sweet oil applied to the vulva and perineum, followed by hot fomentations, has a wonderfully relaxing effect. These measures, re-enforced by a few inhalations of chloroform between pains in the second stage, with proper flexion of the head, have given me results far beyond my expectations.

As a surgical expedient I should advise, and will myself resort to, episiotomy in preference to risking a bad rupture of the perineum in cases where such an accident seems inevitable.

While most earnestly advocating thorough care in the after-treatment of abortions, whether it be curetting, douching, rest in bed, or what not, I would urge you most religiously to guard against this serious condition. Unless

a male physician has gained the unenviable reputation of an abortionist, probably women have more appeals made to them to commit this crime than do men. When over-worked mothers, with large families, or unmarried girls make appeals to my sympathy they always get it; but I tell them kindly and firmly that I cannot commit this sin for the sake of my own conscience, and for the sake of their future well-being. When others come in perfect health offering money, and giving as their reason for not wishing to bear children that they do not wish to tie themselves down, I waste no sympathy upon them and have lost many a good paying patient in consequence.

It will have been seen that I have no new or original methods to offer in urging better and more thorough care of the parturient woman. Verily, I wish I had!

During the past year a mild epidemic of pregnancy broke out among the matured married women of my acquaintance, some of whom had been considered hopelessly barren.

While attending these difficult and prolonged labors I found myself wondering why it was, in this age of wonderful scientific inventions, that a simpler and easier method of peopling the universe had not been discovered.

But as we must still go on assisting women to bear, as best they can, the suffering entailed upon them as a punishment for that first transgression of Mother Eve, let us try by every art not only to relieve them of present pain, but endeavor by every care to get them up in such good condition of health that life may be a pleasure instead of the "drag" which it is to so many, and the condition of motherhood one of expectant happiness instead of a dread.

These women place not only their lives but their future well-being in our hands. Let us not be false to the trust.

## INFANTILE SPINAL PARALYSIS.

BY

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UNDER this name we recognize a form of paralysis which occurs, as the name implies, most frequently in young children, especially during the period of dentition. This disease in all probability has affected children for hundreds of years. And it has not been separated from the other forms of paralysis. As early as 1784 Michael Underwood described a form of paraplegia which occurred in children during the teething period which is now supposed to have been "infantile spinal paralysis." In 1836 Bodham of London described a similar affection in children. Notwithstanding these publications it did not receive general clinical recognition until the publication made by J. V. Heines in 1840. Then this affection was clearly defined, and this form of paralysis was distinguished from other forms of paralysis in children; but previous to his writings this disease was not distinctly recognized as a separate disease, but was confounded with much less serious disorders.

Very little is known of the real cause of this disease, but it is attributed to exposure, dampness, traumatism, dentition, overfatigue carried to exhaustion of the muscles, and some forms of blood poisoning, such as eruptive fevers, diphtheria, lead poison, etc. Many attribute it to the carelessness of nurses in letting children fall or lean back too far until their spine is injured.

This disease occurs more frequently in warm weather, and oftener with boys than girls. It is a disease that usually occurs before the second year of childhood. If you will inquire carefully into the family history of the



patient, you will often find that other members of the family are suffering or have suffered with some nervous affection. I think there is no doubt but you will find this disease more frequent in children born from parents that have chronic disorders, mothers that are nervously wrecked with poor nutrition and bad hygienic surroundings. The vitality of the mother as well as the child depends very much upon the hygienic surroundings, and in order to correct a disease of this kind you must remove them from this poisonous filthy atmosphere that they are compelled to breathe, such as you will find in large tenement houses, to a place where they can be cared for and nourished with good food as well as good pure atmosphere.

The disease is oftenest seen in either the cervical or lumbar enlargement. The condition may be confined to the anterior cornua in the affected region. First the cells become inflamed and their functions are at once arrested; hence sudden paralysis is developed. Later atrophy of the large motor cells; they are either entirely absent or only a few remain.

The affected side of the cord may be considerably smaller than the other. The anterior column may show slight sclerotic changes, chiefly in the pyramidal tract. The acute pigmentary degeneration of the cells so attacked apparently follows as the result of inflammatory and degenerated changes within the cells of the anterior horn. The spinal nerve fibers degenerate as the result of defective nutrition, and the muscles connected with these fibers also undergo rapid fatty degeneration and atrophy. The lesion always in infantile spinal paralysis is in the anterior horn of the gray matter. Whether all of the cells of the anterior horn of the gray matter are motor, or whether they are both motor and trophic cells, are questions which the histological examination of the normal structure seems to be quite incapable of satisfactorily answering.

In infantile spinal paralysis the peripheral disturbance

is in the first place solely one of motility. There is paralysis without atrophy. Paralysis may last six months before the atrophic changes begin, and then these may be active and intense, leading to the destruction of whole groups of muscles and degeneration of the bones.

This destruction and atrophy are not limited to the cells, but involve the nerve fibers in this region, and even the cells and nerve fibers of the posterior horn may become involved.

Sometimes the lesion extends into the white substance of the anterior lateral column. There never has been an autopsy showing the condition of the spinal cord during the acute stage of "infantile spinal paralysis." When atrophy sets in not only do the muscles become smaller, but they undergo active degeneration. Judging from the character of the symptoms of this disease it is probable, as in other inflammatory affections, that there is congestion; that the condition is not limited to the anterior tract of gray matter but is the result of the destruction or impairment of that normal equilibrium which exists between the muscles. Thus, if the extensor muscles of the hand are affected, the flexors may remain unparalyzed; these latter will in time cause a flexion of the hand upon the forearm. If the muscles of one side only of the spine are paralyzed, those of the other side will produce a lateral curvature. If the extensors of the foot are alone deprived of their power, the strong gastrocnemius and soleus cause a talipes equinus. These conditions are more or less modified according as other muscles are more or less involved. The diagnosis of this disease is made often with much difficulty. During its initial stage it is often taken to be toxic neuritis or progressive muscular atrophy, rickets, wasting diseases of childhood, hemiplegia, cerebral or spinal lesions. Occasionally spinal hemorrhage has produced similar symptoms. This paralysis occasionally follows acute diseases, such as diphtheria, meningitis, arsenic poisoning, etc. The acute

variety commences with a stage of febrile excitement which ceases in a short time. Atrophy of the muscles soon follows the paralysis. At times this disease is located with difficulty, and it is not uncommon to-day for some of our best physicians to blunder in their diagnosis.

*Symptoms.*—The symptoms of this disease are classified into three forms, the acute, subacute, and chronic. The subacute never attacks infants. It attacks adults exclusively. The acute form comes on usually with sudden rise of temperature. The fever may last for twenty-four hours, or it may last for days. It is not uncommon at this time to notice some pains in the limbs, muscular twitching, delirium, convulsions, and a sense of numbness which is soon followed with paralysis.

The paralysis attains its height at the onset. It may be confined to one limb or all, one-half of the body or just certain muscles. There is usually some nervous excitement and pain in the back. The pain in the back marks the seat of the disease in the spinal cord to which the paralysis of the muscles is due. It is often not noticed until it has gone on for some time, and then it is observed by the nurse or mother. She notices the child does not use its hands or legs as before. Age helps to diagnose the disease. The circulation of the blood is not good through the parts, so, naturally, the temperature is lower on the side affected, and the first indication of the case getting better is the rising temperature in the part affected.

When atrophy sets in the mobility of the joints is greatly increased; the ball and socket joints may become so loose as to fall out of place, causing dislocation from the lack of tension from the ligaments and muscles; for instance, when the deltoid is affected and becomes flabby and wasted away, the head of the humerus is no longer held in place. Usually as early as the end of the first week the reaction of degeneration is present. The nerves are found to have lost their irritability completely. The skin reflexes and

deep reflexes are usually lost. It is claimed this is one of the most frequent causes producing clubfeet on account of paralyzing certain muscles which hold the foot in normal position. From bone atrophy the limb may become shortened. The disease never affects the muscles of the bladder or anus.

*Prognosis.*—Infantile spinal paralysis is not liable to terminate fatally, and Hammond states that it does not shorten the patient's life. The prognosis is very important as regards the paralysis and atrophy. Some of the muscles may undergo permanent atrophy. If the primary current of electricity is powerless, a cure is impossible. This is one of the means of giving a prognosis. If the muscles continue to respond at all to the faradic current during the height of attack it is safe to predict a recovery. The prognosis must be guided from the amount of paralysis and atrophy. It must not be forgotten that the most extensive paralysis in the disease under consideration may, in great part or entirely, spontaneously disappear before the atrophy begins to make its appearance, so it is impossible at times to get a correct prognosis before the state of atrophy. If the disease creates interference with the action of the respiratory nerve it is possible for a fatal termination to take place.

*Treatment.*—The treatment of infantile spinal paralysis is very unsatisfactory. Most of our neurologists believe in giving ergot at the commencement. Some alternate ergot with bell. to check the inflammation of the cords. But as soon as atrophy has set in they are both discontinued. Electricity is used with good success until atrophy has set in. Some authors regard electricity as being one of the most valuable adjuncts in the treatment of this disease, but it must be kept up for a long period of time. It is used as long as it will cause contraction of the muscles; when it fails to do this it should be discontinued. You should use the faradic current first; if this fails to cause contraction, use the galvanic. The treatment by electricity should be used

every other day. The patient should be kept in bed, especially during the acute stage. When atrophy has set in strychnine is used in small doses, about the 6x. Some authors prefer injecting strychnine into the muscles of the affected parts. You should daily immerse the limb in hot salt water. Use massage, friction, passing movements; cupping is often used over the diseased cord. Ice applied to the spine relieves when there is much fever produced by the cord. In every way you should try to improve the nutrition of the cord and try to relieve the peripheric trouble. Try to arrest the morbid process in the cells of the anterior horns, and even the effect of their degeneration. Much care should be taken to prevent deformity resulting from the contraction of the muscles. You should guard against bed sores.

My experience in treating this disease has been very limited. I have witnessed three cases within my four years' practice of medicine, two boys and one girl. My case was a very interesting one—a boy about eighteen months old, born from parents who were poor. I consented to treat the child regardless of whether I would be compensated for the work or not, for I regarded the experience as worth something to me, for we, as general practitioners, do not witness many of these cases. The mother noticed one morning, after the child was over one year old, it seemed to be so powerless it could not move its lower limbs, and this condition she stated must have come on very suddenly. The child was cross and peevish and at times had fever, poor appetite, pale, puny, and sickly, and it was very poorly nourished. I diagnosed the lesion to be in the lumbar region. I placed the positive pole along the sides of the lumbar vertebrae and the negative upon the gastrocnemius and other muscles of the leg. That caused some little contraction. Internally I alternated ergot with bell. I used this treatment for about one month regularly as well as using other local means, such as massage and rubbing of parts and applying heat to the muscles, and had the mother

to give the child as good nourishing diet as she could, and the child got very much better. I used the electricity three times per week. After the first month I dropped the ergot and bell. and gave nux vomica 3x three times per day. The child seemed to be improving all the time, but after I had been treating it about two months the family moved away and I have never heard of them since. But there is no doubt in my mind if this same treatment would have been kept up the child would have got well. The great trouble in such cases is to keep the mother and child from becoming discouraged with the slow treatment.

Raue recommends internally aconite if the disease comes with the excitable aconite form; bell., calc. carb., and arsenic during dentition; phos. in degeneration of the muscles, and thuja after vaccination.

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## ARTIFICIAL FOODS FOR INFANTS.

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BY

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**A**LTHOUGH the question of artificial food is the subject I propose to discuss, I cannot refrain from saying a word concerning lactation and weaning.

The great majority of physicians to-day admit that Nature's method of feeding the human infant is the best. I say the majority, because I have myself heard physicians say that the first thing to do in preparation for an expected infant's arrival should be the purchase of a cow, as it is easier to control the conditions of a cow than the moods of a mother. The majority of the laity also agree that man with all his scientific attainments can hardly compete with Nature in feeding infants. And yet we all know that the

dictates of society, the conveniences of parents, and the apparent exigencies of certain conditions often deprive the infant of his birthright.

The multiplicity of baby foods in the market, each one in itself perfect (as we are told), and the remarkable success we have all had with some one of these different perfect foods, tend to make us overconfident and careless, and often put us in the rôle of abettors of the crime of unnecessarily early weaning.

The study of artificial foods has taught the profession that quality is not the only factor to be considered in infant feeding; that quantity and frequency are equally important elements for success. This information applied to the normal feeding of infants would frequently obviate the apparent necessity of weaning an infant because its mother's milk does not agree with it, the difficulty being not with the quality, but with one of the other factors.

Too frequent nursing increases the quantity of the milk and deteriorates the quality, not to mention the further disadvantage put upon the child in not giving its digestive organs their periods of physiological rest. Many a case of mycotic diarrhea has been cured by making the baby sleep in its own bed instead of on its mother's arm with her nipple in its mouth the whole night through. This is one of the class of cases which are frequently weaned because the mother's milk does not nourish the baby.

Again, the physiological study\* of the mammary gland has taught us that the milk is not merely a transudation from the blood, but that the active protoplasmic cell is responsible, in part, for its composition; that it secretes more fat, for instance, than could possibly be present as such in the blood; that it manufactures cream out of proteids and carbohydrates as well as out of fats. Furthermore, we learn that an excess of fat in the mother's food, and thus in her blood, interferes with the action of the gland in the production of cream, and results in producing a milk

poor in cream, but rich in proteids and salts—a milk in which there is too large a transudation of blood salts. From this we learn (and physiology teaches us how it is brought about) that to increase the cream in the mother's milk we should increase the relative amount of her proteid food and diminish correspondingly the amount of fat in her diet.

The examination of mother's milk has shown that an increased amount of proteids and salts, and a relatively small amount of fat in the milk, are the conditions usually present where a mother's milk, plentiful in amount and regularly administered, does not make a fat and happy baby. The application of this information would do away with the apparent necessity of weaning many babies.

Menstruation, when it appears during the period of lactation, is usually considered a bar to further nursing. While this puts a double duty upon the mother, and often causes a temporary discomfort, or even illness, for the infant, it should not always be considered a peremptory demand for weaning. If during the inter-menstrual period the child thrives he may make a better gain for the month, in spite of the temporary illness, than if put immediately upon an artificial food. Moreover, the child can be fed for a day or two upon a simple cream mixture and nursing resumed after the menstrual period is over.

Artificial feeding for an infant is always an experiment; the results of the experiment are frequently more satisfactory for a day or two than for months. If we expect to make this experiment a success, to fulfill all of the infant's requirements, and thus make him fat and happy, we must study all of the factors concerned in the problem. "We must think to all points of the compass."

As a rule, the artificially fed baby is more regularly fed than his otherwise more fortunate brother the nursling, and this, to the doctor's credit, is usually because the mother has felt the necessity of having professional advice on the subject. From two to three hours' interval should



elapse between feedings for a healthy infant during the first few months of its life; the physiological demands of the digestive organs as well as the observation of ages demonstrate this to be the most healthful interval.

Accurate measurement of many stomachs has shown that the average baby at birth has a stomach capacity of one ounce, and not until it is about six weeks old does this capacity reach two ounces; that for a baby six months old the average capacity is six ounces; and the child must reach the age of ten months before it can normally accommodate eight ounces, the full measure of an ordinary nursing bottle.

Yet babies at birth are often given a full eight-ounce bottle of food and allowed to pull at it until it is emptied; then quickly supplied with another, to be literally kept twenty-four hours of the day, asleep or awake, with a nipple in their mouths. These are the babies who have tried all the foods—milk, fresh, condensed, and sterilized, the prepared foods of the market and homemade concoctions—and still are not satisfied or even well. This state of affairs is in part due to the fact that the mixture fed them is often diluted to the extent that many fold the normal bulk must be consumed to obtain the necessary amount of food principles.

The most reliable analyses of human milk give the following approximate results:

TABLE I.

*Human Milk.*

Reaction, . . . . .	Slightly alkaline	
Specific gravity, . . . . .	1028	1034
Water, . . . . .	87	88
Total solids, . . . . .	13	12
Fat, . . . . .	3	4
Albuminoids, . . . . .	2	1
Sugar, . . . . .		7
Ash, . . . . .		0.2

Another important factor shown by experiment is that human milk is sterile.

It is not enough to supply a food that is easily digestible; it must at the same time be nourishing, and furnish the proper relative amounts of the different food principles.

Except for the elements included under the term "albuminoids" this is a wonderfully simple mixture. At least two albuminoids, casein and liquid albumin (in all respects similar to serum albumin), are present, their relative proportions varying under different circumstances.

The more one studies the formula of human milk the more one realizes that science is unable to make any mixture, without the use of milk, that introduces all of these necessary elements in anything like as simple a composition.

This has been appreciated by the manufacturers of infant foods. All of these foods in the market to-day which have won for themselves any favorable notice have incorporated in their composition milk in some form, or are expected to be mixed with milk before being used.

Cow's milk is the only form of milk which is obtainable by all persons as a substitute for human milk, and while it does not approach quite as nearly in one or two particulars to the standard of human milk as ass's or goat's milk, yet it is just as easy to make it chemically resemble human milk.

Let me recall to your minds its chemical composition.

TABLE II.

*Cow's Milk.*

Reaction,	.	.	.	.	.	.	.	Slightly acid
Specific gravity,	.	.	.	.	.	.	.	1032 1036
Water,	.	.	.	.	.	.	.	86 87
Total solids,	.	.	.	.	.	.	.	14 13
Fat,	.	.	.	.	.	.	.	4
Albuminoids,	.	.	.	.	.	.	.	4
Sugar,	.	.	.	.	.	.	.	4.5
Ash,	.	.	.	.	.	.	.	0.7

Bacteria are always present in that delivered in the ordinary way.

We find that the sugar contained in each is the same in composition and behavior; that the ash, fat, and liquid albumin are practically the same; but that the casein is radically different. Its most notable difference is the way it coagulates under the influence of heat and acid. The casein of human milk coagulates in fine flakes; that of cow's milk in solid curds. If, however, the milk is diluted with five times its bulk of water, the casein curds can be made to resemble those of human milk in fineness.

In the laboratory these curds are found to be finer when the menstruum added is pure water, rather than solutions of limewater, starch, or any of the prepared foods. The time-honored custom, which we have all used, of diluting the milk with barley water or oatmeal water, certainly satisfies the requirements of some babies' stomachs better than a pure milk and water mixture will, and we are forced to confess that there is some factor present in the coagulation which chemistry does not explain. One fact has, however, been demonstrated by observation and experiment, viz., that the casein in cow's milk taxes the digestion of the infant less if its proportion is reduced to not more than that found in human milk—one-half per cent.

The other important factors in the problem of quality are to change the acid to an alkaline reaction and to render the product sterile. To sufficiently diminish the proportion of the casein has been the aim of physicians and the manufacturers of infant foods for a long time, and in different ways it has been accomplished. But as a result babies have been fed upon mixtures containing too little nourishment—when there has been a notable deficiency of fat and sugar—and they have been obliged to distend their stomachs by consuming two or three times the bulk of food that they were intended to take at a time.

Milk one part and water one part, milk one part and

water two parts, unsweetened condensed milks diluted according to directions, are all deficient in sugar and cream, as can be seen by comparing the tables quoted above. The sweetened condensed milks introduce an excess of sugar in a form foreign to pure milk, and as they are about fifty per cent. cane sugar, are relatively just so much poorer in cream when diluted.

If you study the formulas of the best prepared foods, as Mellin's, Nestlé's, Carnrick's, Imperial Granum, and others of these types, you will find that while the albuminoids have been reduced to about the proper standard, they are all woefully deficient in fat, and many of them in sugar. Moreover, they have all introduced some new factor, such as starch, dextrine, or glucose, which Nature did not consider necessary, and for the care of which she made no provision in the infantile organism. These foods, as a rule, are alkaline and have been made sterile, and this undoubtedly explains why formerly some babies have done better upon them than upon a single milk mixture.

These foods are at times of great value in feeding babies in spite of their defects, and we shall find that the better we understand their various compositions the better use we can make of them.

In preparing them for nurslings, the addition of cream in sufficient quantity to bring the mixture to the standard of human milk is desirable. If cream cannot be obtained, its best substitute is proteinol. Proteinol contains in a stable form digestible fat closely resembling cream, and contains no elements which render the mixture hard of digestion. While each of the better forms of infant foods has been of service and has successfully nourished many babies, it is a fair inference by analogy, and a truth borne out by observation, that the food mixture which most closely resembles Nature's mixture will suit the greatest number of babies. By such a mixture I mean one which not only contains the same, or the nearest to the same, ingredients

in the same proportion, but also one which introduces the fewest and least harmful extraneous ingredients in the smallest amounts.

Although I have allowed my subject to run away with me, and fear I have overtaxed your patience, I cannot leave it without a word concerning sterilization of food. I thoroughly believe in sterilization of all foods, and appreciate the infinite help it has given us in the question under consideration. I believe in sterilization of milk by prolonged moderate heat rather than by a high temperature, because chemistry shows us that boiling devitalizes milk and changes fluid albumin to its disadvantage as a food compound for infants. It seems to me, however, that the profession are neglecting the truths they have already learned in the stress they are putting upon the question of sterilization. Some babies will thrive on sterilized cow's milk, pure and undiluted, but they do so at an unnecessary expense of digestive and eliminative effort. The excess of albuminoids may not cause diarrhea, but the elimination of the partially oxidized albuminoid compounds may cause nerve storms, nephritic or cystic catarrh, or apply the torch to an arthritic inheritance.

## SEXUAL ERRORS.

BY

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THE only explanation I offer for presenting this subject in this vague manner is because the literature upon this subject is not of such a character or in such a truly practical physiological form as to warrant reference thereto, only to criticise it; and I do not believe such a criticism would be of interest or advantage here. Therefore I present this subject in a wholly original manner, soliciting your candid consideration and investigation, and I hope to have your thoughtful criticism now, and later, when you may be able to give the subject the consideration it merits at your hands.

The influence of the sexual system upon life, health, capabilities, character, and dispositions is not yet well known, or, if well known, not allowed to be fully considered as the cause of disease phenomena, or disease disintegration of organs.

"The human body, when it has attained a development nearly complete, is the least exposed to sickness from transient influence or from the deprivation from its accustomed food, because the powers of life existing in their integrity overpower any injurious effects from such before they can make any progress." (Bradford's "Life of Hahne-mann," chap. xxii.)

Mothers, fathers, and health educators—physicians—give too little attention to the sexual system and the part these organs play in the rôle of health and disease. No function of the human body is so much abused, not even the stomach. To no system of the human economy do we owe greater allegiance than to this, the sexual system. All sensuality,

pruriency, irritability of mind and conduct, as well as immodesty, come of unnatural or morbid conditions affecting the sexual system, or affected by the sexual system.

The brain centers, which receive and conceive all sexual impulses, likewise distribute all other impulses and emotions, which are reflected to the surface, and stand out as nature's guideboards to the key of the personality, health, and disease. All nervous diseases, irritable dispositions, emotional natures, and incentives to immodesty, vice, and crime may not always originate from the sexual system, but their causes are closely allied to this system. Varied conditions of the sexual system will produce these troublesome characters and diseases, more lingering and more dreadful, and in the advanced stages as incurable, as pulmonary consumption or general tuberculosis, and even death.

To discern the tendencies to sexual pruriencies in the infant and child, and advise a regimen and therapeutics specifically adapted to each individual, with wholesome instructions to parents or guardians to continue proper watchfulness and medication, is the province of the physician and his or her duty, just as much as in worms or a predisposition to tuberculosis, diphtheria, or croup.

June 10, 1876, was called to see a Miss W., aged seventeen, of good family, who I was informed had been suspected of having too much intimacy with a young man far below her position in society; and her brother leveled a gun upon the intruder, demanding that he retract his saying that he had held such unlawful intimacy at her own solicitation. The young man insisted that it was true, and if he did not believe him, examine the labia, where could be found a mole. This apparent impudence and boldness caused the brother to reflect and attempt to investigate whether he was right in his assertions or not. The mole was found and the young lady gave a history of constant sexual excitement producing a condition of irresponsibility.

The parents were regular attendants upon the services of the M. E. Church, and the young lady was always with them, an active and willing worker in Sabbath school, a modest and retired though delicate-looking lady. The mole was removed and the indicated remedies given with gratifying results, a return of youthful appearances, and freedom from sexual pruriency and its deprecatory results, mental and physical.

July 12, 1887, was called to Mrs. R., aged twenty-seven, a slender brunette. Found her helpless in bed with recurring spasms of dyspnœa, an anxious expression, and general cold copious perspiration. Was relieved soon by arsenicum, when she gave me the following history: Early in life was a victim of incontrollable sexual impulse; married at seventeen, had three children, which perished early, and husband died soon after last child. In about one year married again. No children since. Husband strong and robust. She felt as if she could hang with her arms about his neck continually, with strong sexual impulse. Had been treated by three different physicians, who did her no good apparently. "I did not know any harm came from these impulses."

During my visits, thirty-four in all, I failed to find any organic lesion or other serious functional disturbance than hyperæmia of the sexual system, and the ill effects of this condition upon the vitality of the patient. Patient informed me that no other physician had given her any information about the cause of her paroxysms. September 10 of the same year she died.

Every physician of experience and observation can relate truths of sexual pruriency in children—children who incline to play with their sexual organs, the male often irritating the glans penis or prepuce so much as to cause phimosis or paraphimosis, not infrequently priapism. Girls are found to insert foreign substances into the urethra and vagina, or titillate the parts gently, causing by reflexes



ovaritis, early in life developing various morbid conditions of mind and body.

Mrs. —, a daughter of wealthy parents, was educated and given lessons in healthful and often arduous labor, which may have been the cause of her being well developed and rugged. She informed me that she had suffered all kinds of local uterine punishment from toxic uterine and nerve medicines without any beneficial results—rather the opposite. After marriage all such treatment ceased, and the apparent necessity ceased also. The husband was as strong and robust, and probably as prurient sexually.

Of the children, six in all, one died at the age of six. Of three girls the eldest very prurient, the second had heart disease, and died at nineteen, the youngest an epileptic; the affection scarcely recognizable as such in infancy, but became more marked as she grew older.

From early in life to the present was constantly inclined to titillate or rub the labia, and sometimes produced considerable soreness about the meatus of the urethra. Was apparently idiotic, at times growing wild and vehement, at other times calm, reasonable, and loving.

At the age of ten years was difficult to restrain, and her conduct caused the mother to fear that some male without the instincts of right, or the fear of criminality, might bring sorrow to their hearts, and leave memories which would remain upon the whole family as an apparition of ghastly horror never to be effaced.

At the age of eleven the child was examined closely, hoping to find some intra-cranial cause for the phenomena, applying the diagnostic electric keyboard, and close study of all objective and subjective symptoms. A hooded clitoris and evidences of long-continued irritation of the vulva and vagina were found, the orifice remaining distended, open sufficient to admit the tip of the index finger without difficulty when the thighs were abducted. The mucous surface was thickened and covered by hardened epithe-

lium around the margin of the vaginal orifice, and the os uteri was almost visible without the slightest distention.

The hooded clitoris was relieved and the patient placed under the especial care of a competent nurse, with full instructions to observe and prevent any attempt on the part of the patient to excite or gratify any sexual desire, and to rigidly maintain a watchfulness and report all observations. She was maintained in this way about a month, when, by my urgent request and with every reason which I could urge, a surgeon was induced to remove the ovaries and tubes, and to his surprise found both ovaries in a condition of hyperæmia, and one (the right) completely enveloped in a cyst. I endeavored to induce the surgeon to remove the uterus, but failed in this latter.

On the 17th of October an operation was done for microcephalous, as follows: "A groove on the left of the median line, extending from just back of the hair line, six inches long and three-quarters of an inch wide," was made.

From this operation the patient recovered without the least untoward symptoms, and the surgeon made the following comments upon the conditions observed: "The bone was intensely hard, and the rongeur forceps could not cut it in places. The division between the plates was practically absent. I never worked in such hard bone." This hardened bone was doubtless due to a long-continued hyperæmia of the cranial viscera. After the electrical diagnosis and the relief of the clitoris the convulsions abated for a time, but returned with the former severity.

Since the ovaries were removed and recovery was complete from the cranial operation and the child returned home she has been incorrigible, the mother being unable to restrain her in the least. "The paroxysms seem more frequent and more severe," writes the mother, "and the sexual exhibitions no less, but I have relief from the dreadful fear that the child may become *enceinte*."

In the present undeveloped state of the public and pro-

fessional mind upon this subject I have accomplished my object if I have succeeded in arousing sincere thoughts upon this serious and deplorably neglected cause of disease of infants, and the misery and crime of adults which are reflected upon their progeny.

I say reflected upon their progeny, for it is a fact that sexual debauchery is a disease and produces a distinct constitution and character, and is susceptible of cure, and if timely recognized and properly treated could be prevented and thus avoid the sexually prurient constitutions.

As Gallavardin has demonstrated that alcoholism is a distinct disease, and *curable*, so is sexual pruriency. I warn my associates that no mock modesty or traditional conversatism upon this matter, the sexual question, will free them from their rightful responsibility for much of prostitution, debauchery, and insanity, due to neglected infants through ignorance or supposed modesty in sexual idiosyncrasies. When honorable physicians admit their inability to cure sexual pruriency by advising immoral and illegitimate coitus, is it a wonder that so much vice of this order abounds?

A young man, of good family, less than twenty years of age, came to me inquiring, "What is the matter with my privates?" Upon examination I found soft chancre, and asked him if he had not been taught not to be guilty of illegitimate sexual cohabitation. He said that his father said to him that he must not bring disgrace upon himself and parents and sisters, or trouble upon helpless or ignorant girls, by fooling with servants or other girls, but if he found it necessary to indulge in sexual matters he should go where they sold such indulgences.

I have been called to advise boys fourteen years old who had contracted gonorrhea, and girls at twelve with specific leucorrhœa. Is it any wonder that the world is full of sexual immorality, vice, and crime?

## NEURASTHENIA.

BY

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IN the term neurasthenia we have been taught to include all manifestations of the condition commonly known as nervous exhaustion. It may be manifested in a variety of ways; its symptoms will depend upon the type, cerebral or spinal exhaustion, and also special idiosyncrasies.

Neurasthenia, while not in reality a disease in itself, constitutes the basis of many of the functional diseases with which the general practitioner come in contact.

Nervous exhaustion in its objective symptomatology presents the following phenomena: epilepsy, chorea, hysteria, hysterio-epilepsy, catalepsy, insomnia, dyspepsia, sick headache, hay fever, morbid fears, sexual debility, etc.

Neurasthenia may affect the cells of the brain or the spinal cord separately, in view of which we are led to recognize two types of neurasthenia, the cerebral and the spinal.

Cerebral neurasthenia (brain exhaustion) may be indicated by one or more of the following symptoms: Tenderness of the scalp, pains in the head, fleeting neuralgias, sleeplessness, vertigo, a tenderness and pallor of the gums, abnormal sensitiveness of the teeth, blanching of the hair, flushing of the face, dilatation of the pupils, idiosyncrasies in regard to food, sexual irritation, mental depression and melancholia, defective memory, morbid craving for alcohol, decrease of intellectual capacity, buzzing or ringing in the ears, specks before the vision, abnormal and imaginary impressions, thickness of speech, numbness of the limbs, weakness in the muscles. These are but the manifestations of weakness. The electric batteries of the brain (the brain cells) are feeble or uncertain in their action.

They are incapable of performing their office. They are not diseased (in a medical sense), but are liable to become so sooner or later.

Spinal neurasthenia (spinal exhaustion) signifies an exhausted state of the cells of the spinal cord. The cord itself is composed of nerve cells distributed into bundles of nerves. Some of these nerves pass through it to reach the brain, while others become united to the spinal cells and pass no farther. The cells of the brain and cord are practically electric batteries, and the nerve fibers are the wires by which they are communicated with the different organs of the body, the muscles, skin, joints, and viscera.

The spinal cord is under the control of the brain, but is capable of extending under certain circumstances a control over all acts which are termed "reflex acts," such being to a greater or less extent independent of the will. The symptoms of spinal irritation differ materially from the cerebral.

Among its chief manifestations may be mentioned the following: A tenderness of the skin to touch or pressure; tenderness along the spine or over certain limited portions of the spinal column; irritability of breasts, ovaries, and uterus; fleeting pains of a neuralgic type; pulse rapid or slow, fluctuates during periods of excitement or fatigue; palpitation of the heart; dryness of the skin or in many cases the reverse; excessive perspiration of the hands and feet; sudden starting on going to sleep; twitching one or a group of muscles; chilliness and creeping sensation along the spine; numbness or abnormal sensation of heat in the skin of the body or limbs; itching of the skin; eruptions of the skin, chiefly of the type of eczema; frequent yawning or stretching; frequent seminal emissions; weakness of the bladder and rectum; and disturbances of the digestive functions.

The distinction between cerebral and spinal neurasthenia, which has been stated by many observers to exist, cannot be made in each and every case, because various conditions

of the symptoms of the two are often encountered in the same individual. An irritation of one point may be transferred to any other point, following the paths of least resistance, and making itself felt in those that are least able to resist molecular disturbances. Thus, for example, seminal emissions (spermatorrhea), when they arise through abuse or disease of the spinal cord, almost uniformly react on the brain.

A decayed tooth has been known to cause a persistent earache, and in one case to cause the corresponding eyebrow to become white. In male children a tight foreskin not infrequently causes sufficient irritation of the sexual organs to induce spasms or paralysis of the lower limbs by an indirect effect upon the spinal cord.

Neurasthenia is not of itself a condition that leads to a fatal result, but lesions of the brain and spinal cord develop as a sequel of the neurasthenic state.

Thus far I have followed and quoted Ranny in his "Nervous and Mental Diseases," title "Neurasthenia," and while following and quoting several questions arose in my mind, which it would be well to solve if such a thing be possible. In trying to effect a solution let us ignore theories and preconceived opinions, many of them handed down to us through the past generations with nothing to recommend them save being of sear and hoary age.

We are told by authors of books and taught in the medical colleges that neurasthenia is "nervous exhaustion," that following in the train of this condition are certain phenomena, and that when these are found embraced in the economy of a patient we may safely pronounce the case to be "neurasthenia." Nervous exhaustion means, as a rule, a low condition of the system; its approach has been insidious and stealthy, one bad symptom following another, until the totality of symptoms is formidable in the extreme—much more so than the name, which of itself is bad enough.

In neurasthenia what system of nerves is in a state of exhaustion primarily? what system of nerves presides over and controls the vital machinery of the economy? which nerves or what group of nerves assimilate the food, remove the *débris*, repair all deficits, propel the blood, supervise the action of the liver, the kidneys, the bladder, the alimentary canal, the uterus, the skin, the lungs, the heart—in short, all the internal machinery of the body?

Books are written and we talk about mental diseases, and a chair is endowed and filled by some member of the profession who is required to teach the *modus operandi* of treatment of mental disease; but, seriously, is there any such thing? Disease in a medical sense implies the existence of tissue, body, parts, physiology, and anatomy.

Disease implies that something morbid has attacked the tissue and pathology begins. By what method is the pathological change to be traced on a patient's mentality?

Can we minister to a mind diseased? I answer, No. But we can minister to the tissues whose office and function are to produce that subtle thing known as mental action.

Mentality is only the result of the natural attributes the equipose of which produces phenomena. Destroy the equipose and the natural action becomes impaired.

In all or nearly all cases of dementia, insomnia, hallucinations, etc., nervous irritation is the prime condition, the leading characteristic feature, of the case. In these cases where does the medical man look for pathological development such as would produce the phenomena present in a typical case of so-called mental disease? In very many cases of *post-mortem* examinations of persons who died in insane asylums, in which it was confidently expected by those who were in charge to find extensive pathological brain changes, to their great surprise the conditions were normal in every respect.

Now if the brain tissue, the seat of mental activity, in such cases is found normal, why locate the condition in the

cranial viscera and allopathically call it a mental disease? How call it a disease if the organs producing the phenomena called mind are normal? Where is the seat of pathology that causes aberration and want of co-ordination of the intellectual faculties?

In the twenty-third report of the Middletown State Homeopathic Hospital at Middletown, N. Y., the physician in charge of the women's department reports as follows:

"The ability to speak with anything like competent authority on this subject [viz., diseases of women as found in hospitals for the insane] would necessitate observation and investigation extending over a much larger period than six or seven months. Consequently, what will be found in this paper must be little else than a plain statement of conditions observed among insane patients, whose symptoms have pointed to the advisability of an examination of the generative organs. Out of sixty-one examinations of the reproductive organs of insane women, only six cases have been found which could be pronounced normal. A few had only slight pathological conditions, and five or six were so resistive as to render an examination so unsatisfactory as to be practically useless. Many more examinations might have been made, but the majority of those who were examined required treatment.

"This large number of cases wherein abnormalities were found may at first seem quite appalling, but it must be remembered that out of over five hundred insane women only those have been examined who presented some special indications.

"The table of cases examined is as follows:

"*Menses*.—Quantity: abnormal, 31; normal, 21; regularity: regular, 25; irregular, 17; passed the climateric, 14; no menstruation, 2; dysmenorrhœa, 5.

"*Position of uterus*.—Normal, 22; retroversion, 17; anteversion, 6; undetermined, 6; lateroversion, 2; very high in pelvis, 1.



"*Body of uterus*.—Normal, 6; hypertrophy, 8; atrophy, 9; small, 3; congenitally small, 1.

"*Cervix, size*.—Normal, 2; hypertrophy, 6; hypertrophy of anterior lip, 2; hypertrophy of posterior lip, 1.

"*Condition of cervix*.—Normal, 2; erosions, 20; laceration, 5; soft granular erosions, 3; pinhead os, 1; polypus in os, 1.

"*Perineum*.—Ruptured, 8; slight erosion, 1; new growths, 1; urethral caruncle, uterine polypus, interstitial fibroid, uterine polypi, 2.

"*Anomalies*.—Vulva like a child, 1; body of uterus rudimentary, 1; vagina mere *cul-de-sac*, no trace of uterus or ovaries, 2.

"*Condition of ovaries*.—Sensitive in region of ovaries, 4; ovaries removed, 2.

"*Leucorrhœa*.—Profuse, 28; offensive, 8.

"*Masturbation*.—Very bad, 17; not, 1; suspected, 4.

"*Condition of vulva*.—Enlarged nymphæ, 9; vulvitis, 3; a trace of nymphæ, 1; pruritis, 1.

"*Condition of vagina*.—Vaginitis, 5; cystocele, 2; rectocele, 1; prolapsus, 1.

"*Mental condition*.—Chronic melancholia, 3; acute melancholia, 8; acute mania, 9; subacute mania, 13; terminal dementia, 7; masturbation dementia, 1; melancholia, 4."

Such is the report of Dr. Clara Barrus, surgeon in charge of the insane women of the Middletown Hospital at Middletown, Orange Co., N. Y. Where is the pathology in these cases. In what direction does the finger of observation point? In the cases reported the examination is confined to the sexual organs principally.

Dr. Barrus makes a mistake when she says that "hemorrhoids, rectal pockets, anal fistula, etc.," are not diseases peculiar to women. The alimentary canal, and especially the rectum, seems to be as much a factor as the sexual organs in all mental phenomena. Truly it has become a necessity to revamp, remodel, and amend our thoughts, our actions, our books, and our remedial measures.

## ● EDITOR'S TABLE. ●

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IN his paper on pelvic surgery read at the Denver meeting Dr. W. E. Green stated that it was not his intention to treat the subject of pelvic surgery in a highly technical way ; his object was to touch upon its salient points and draw out a discussion that would comprehend our ablest operators. A knowledge of pelvic pathology is essential to a proper understanding and appreciation of the diseases of this region, and on this factor, more than on any other in a physician's requirement, depends his success in their management. Infection of the pelvic structures is usually of uterine origin, the sepsis passing along the fallopian tubes ultimately reaching the pelvic cavity. After describing the mode in which infection is ordinarily carried to the pelvic parts, he said that occasionally a more important feature of pelvic infection than disorganization of the tubes and ovaries, one that is often caused by delay in operating, is the bowel, bladder, and omental complications. Since the laws of morbid anatomy apply alike to all regions, so also should the broad principles of surgery govern here as elsewhere. Who would, in this day of surgical progress, aspirate an abscess of the liver, leave an empyæmic pleuritis to a spontaneous evacuation or a gangrenous limb to nature's amputation ? Yet, if we are to believe what we read and hear, there are those who would treat a pelvic abscess by the expectant method, a disorganized ovary by electricity, or a pus tube by dilating and curetting the uterus. There is a consensus of opinion that diseased and occluded tubes with retained secretions, and degenerated cystic or suppurating ovaries, never return to a state of physiological health and are not amenable to therapeutics. The purpose of surgery is not always to establish physiological function or restore perfect form and health. The object may be to stop disease, though at the sacrifice of organ or limb. No sentiment of conservatism should prevent the total ablation of the womb and adnexa when they are diseased so that their function is destroyed. Diagnosis ranks next to pathology in the knowledge of the expert. A vast amount of technical knowledge, tactile

sense, careful discrimination, and experience is necessary. It is the abuse of surgery that has brought discredit upon the art. Many valuable lives have been sacrificed through delay in having a laparotomy performed through the belief that a laparotomy is extremely hazardous, to be done only as a last resort. Opening the abdomen is not necessarily a serious operation. Danger lies not in traumatism, but in sepsis. One of the most important elements in successful pelvic surgery is drainage. The kind of drainage depends upon circumstances. When adhesions are extensive, leaving denuded a large surface of the peritoneum that will cause much exudation of serum, a glass drainage tube is preferable. When pus has been found, the iodoform gauze may be selected—should be used in abundance, placed deep in the cavity, and allowed to protrude from the abdominal wound. The closing of the wound requires two rows of sutures, one deep-buried and the other superficial. The cut surfaces should be brought together closely with a medium-sized catgut suture, and the other structures carefully brought together with silk. In using the silk sutures a curved needle should be used, entering near the cut edge, passed outward, downward, then inward with a sweeping curve, emerging below in the muscular layer, but not piercing the peritoneum, then re-entered on the opposite side, and passed with the same curve upward, and brought out in the skin at the same distance from the cut edges. Hernia will never result when an abdomen is closed in this way. Dr. Green regretted that time would not permit him to refer even briefly to the other many details of the work that would prove interesting, such as anæsthesia, length of abdominal incision, the Trendelenburg position, after-treatment, diet, etc., as these are all very essential; he hoped, however, that the discussion would bring that out.

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CONTINUING the discussion, Dr. McDonald said: The first thing about Dr. Green's paper that attracted my attention was his remarks with reference to the devastating effects of pus. That one point alone is of sufficient importance to make a paper. I don't believe there is a more important subject than a knowledge of the

influence of pus upon the human economy. It is not sufficiently studied or taught. I believe we shall have fewer cases of malarial chills and other kinds of chills when the student has once learned the great value of recognizing the influence of pus. It ought to be burned into his brain. One thing that Dr. Green has omitted is the possibility of prevention of just such conditions as the doctor has written about. Many of these diseases he has written of, such as pelvic abscess, are due to infection, and many of these to carelessness, and many to old metritis, introduction of dirty specula, probes, and fingers, and the very fact that many of these cases of endometritis and parametritis are relieved by curetting and thorough irrigation argues in favor of the limitation of transmission. Many of these abscesses that occur in the broad ligament do so by transmission in and through the tubes from the fact that the broad ligaments are in juxtaposition to the tubes. There is some danger, I think, of jumping to conclusions when he insists upon the removal of every diseased organ and tissue—the removal of the sexual organs no matter what the disease may be; he is not so radical as that. He doesn't mean that he recommends removal of every ovary that is suffering with inflammation, or of the uterus that is in the clutches of parametritis. I have been in consultation with him, and I know that he advises the non-removal. He is just as conservative as anybody else, provided there is a possibility of relieving them by other means. When they cannot functionate and are accompanied by unmitigated suffering to the patient, then he advises their removal. But at the present time I think the trend is toward conserving as much tissue as you can save. We have removed a diseased ovary, even when the woman was pregnant and the child was born alive and at full term, leaving every particle of sound tissue that will functionate. If Dr. Green did not do this, it would be just as consistent for him to remove every penis that has gonorrhea. With reference to the drainage, I confess that my preference is for tamponated gauze. With reference to the stitch that he uses, I admire it very much and shall try it at my very first opportunity. I believe in bringing the muscular tissues together. I believe it is much safer to go into the abdomen through the muscle.

**D**R. WARD of San Francisco said : It is my intention to simply challenge one point of Dr. McDonald, and that is the line of infection as interpreted by him. He contends that it has two lines, one through the lymphatics and one through the uterine mucosa on into the peritoneal cavity. It hardly seems to one who opens the cavity frequently and finds the ovaries adherent, it is not likely that he will find any lymphatic enlargement along the line of the broad ligament. It is hard to conceive how infection can travel along that line and find its way into the peritoneal cavity. In cases following parturition where there is a traumatism and the infliction of an injury where absorption is limited, there we can easily see how it could pass along the line of the broad ligament and end in the iliac region close to the iliac wall. But in ordinary gonorrheal infection and the worst ravages of peritoneal inflammation how can such infection go through or over the lymphatic vessels? That is the one point in the discussion of the preceding doctor that I would take exception to. It must be limited to cases of parturition where the infection goes along the glands. As to drainage : Our experience has gone through every line and form of drainage tube both European and American. In the last year it has limited itself simply to one glass drainage tube, straight and perforated and with large openings, so large that the extravasated blood may pass through. If the tube is bent, the greatest difficulty is aroused in turning the tube, for it must be turned every twenty-four hours to keep it from plugging up. The glass tube, as introduced by Joseph Price of Philadelphia, is undoubtedly the best kind of drainage. The approximation of the tissue is in accord with our view of the situation ; then you will have but very little tendency to ventral hernia. If you get the perineum approximated by catgut sutures under aseptic precautions, the close of the rest of the wound is comparatively unimportant.

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**I**N addition Dr. McDonald said in reference to the passage of infection through the lymphatics that he had a case of hematemia not long since and had seen reported some eight or ten cases of abscess in the broad ligament without any parturition or anything else of that kind. This writer took the position that it must have

of necessity become infected through the broad ligaments, and the abscess was in line—in continuation with the tube. In the majority of cases the infection is otherwise.

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**D**R. REUBEN LUDLAM said : One or two little points may be of interest. I have several times shown how it is possible for an abscess to become very infectious—an abscess from the broad ligament, and particularly of the left broad ligament—through other sources than have been named. It has been proven over and over again outside of my clinic. I know that such an abscess may become infectious through what has passed into it through the rectum. I have several times shown my class cases where I have tapped and drawn off the pus so as to prevent the rupture and discharge into the peritoneal cavity, and we have had the same odor as of fæces. The first time I thought I had opened the bowel. Where the gas has not passed into an abscess on the other side, the pus is not always noxious. This is one criticism I would make on the original paper : Nothing was said about abscess in the pelvis in which the pus is non-infectious absolutely, as simple and non-infectious as milk. We take the same pains to get it away and do not allow it to overflow into the abdomen, because we don't know which is which until it is tested. But there are such cases, and I have seen the record of these cases also in some French authorities, where this pus has been taken and tested at once and been found perfectly and absolutely non-infectious.

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**D**R. PRATT said : Inflammation is the battlefield, and like any other battlefield it is covered with the dead and the dying, and the poisonous nature of the infectious material lying about depends entirely upon the rapidity and thoroughness with which the dead are buried ; if it be not promptly done, infection and disease of all kinds attack the immediate survivors. We have to look over all the battlefield for our dead. What are the veins for, the lymphatics, but to carry away effete matters from the system nearest to them by a very broad anastomosis ? They go almost straight from the point where they find the *débris* to the lymphatic glands. The tendency is to carry infection from the

terminus of the lymphatics to the lymphatic glands. There is another channel or set of channels by which the dead are buried. It is the most useful one of the entire army. That is the capillary system—the capillary of the blood vessels which communicate with one another. Let the vagina become infected and we know that that would disorder the whole sexual system. I know that a misfortune in the family will disturb that whole family. If a boy is drowned, the whole family suffer. Let the vagina be troubled: the news is instantly telephoned from one part to another until the whole sexual apparatus is alarmed. I understand how blood corpuscles can carry mischief from one part to another, and when that becomes affected the remainder are easily tainted and become diseased. I believe that infection from one part to another is done mainly by the capillaries under the influence of the nervous system.

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DR. GREEN, in closing the discussion, remarked that the fact had been fully established that infection can take place through the chain of lymphatics—those that pass up alongside of the uterus. In one case cited he was pretty certain infection took place that way. She did nicely until the eighth day; on the eighth day the infection took place and she died on the eleventh. He could not account for the infection in any other way. As to the closing of the abdominal wound, he is very careful to bring not only the peritoneal edges together, but the fascia as well as the muscle, thus endeavoring to bring like tissues together.

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DR. O. S. RUNNELS' paper on the surgical treatment of tubercular peritonitis was an exceedingly valuable one. Before the introduction of the exploratory incision, said Dr. Runnels, very little was known of tubercular peritonitis. It was mere speculation and conjecture; and all was empiricism and expectancy. Had it not been for the mistaken diagnoses of Spencer Wells and others in the surgical treatment of ovarian cysts this ignorance would still continue. If they had always encountered the presupposed cyst in their abdominal section instead of occasionally finding only free liquid in the peritoneal cavity, or a con-

glomerate of matted omentum and intestines with widely disseminated tubercular deposits, they would not have known of the disappointments of an abandoned operation, and they would have seen cures result from such apparently barren procedures. Soon the lessons of accident were turned to utility, and Koenig had the great merit of first coming forward with the bold proposition to make cœliotomy the deliberate remedy in tubercular peritonitis rather than a mere fortuitous procedure. Tubercular peritonitis is essentially a surgical disease and cannot be successfully managed without surgical intervention; and that it is curable by cœliotomy, that bacillus culture can be arrested if it has not gone too far, and that the bacillus is a *post hoc* is now admitted. All surgeons of to-day with any experience in this matter have seen from thirty to fifty per cent. of the cases recover under surgical treatment which had proved intractable under all other forms of procedure. How does such a simple thing as a cut in the abdominal wall cure so formidable a malady? One claims that it is because of the evacuation of the contained fluid, and another that it furnishes the chief means for the dissemination of the tubercular deposits, the implantation of ptomaines, by floating them to new grounds, and that by removal this source of contamination and autoinfection is suppressed. The reasons for this I think are now comparatively clear. Since the better realization of the part played by the sympathetic nervous system in the realm of the organic life, we understand that irritations apparently the most trivial are capable of reducing life capital, that removal of the thorn from the flesh is a primary requisite to restoration, and that sympathetic ganglia discharge untold volumes of force as the result of sudden demand or shock. Nothing can make a more profound impression upon the life forces than the invasion of the sympathetic precincts by cœliotomy. Why it does so none can tell.

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DR. REUBEN LUDLAM said: I have had the pleasure and the privilege of reading Dr. Runnels' report in advance of this meeting, and have found it to set forth many points of interest. This form of peritonitis is essentially and in the majority of cases, I believe, a surgical affection. How a simple



incision made with exploratory intent, with drainage, is of such striking advantage in suitable cases we do not know. Of its *modus operandi* the essayist has well said : " All that is clear is variance of opinion." How it arrests the development of the growth of the tubercle bacillus that is already growing in a favorable soil we do not know. How it destroys these parasites, and turns the miliary deposits into fibrinous and innocuous bodies or removes them by absorption, we do not know. But the fact that by it the local disease may often be arrested is susceptible of the best kind of clinical proof.

The added and the very important fact that in obscure cases it affords a most excellent means of establishing the diagnosis is a double justification for its employment. For with all our boasted insight we cannot certainly know or guess what lies behind abdominal walls. Only a careful section can disclose the morbid contents of the peritoneal cavity ; but in my judgment it would be very wrong to open the cavity if one did not know just what he had found when the conditions were exposed. In this day, especially, some safeguard should have been thrown around this diagnostic expedient by the essayist. An unqualified recommendation to open the abdomen in all cases of suspected peritonitis of this sort, without a word about the risks of such a procedure in the hands of the majority, or concerning the general ignorance of peritoneal pathology, may do a great deal of mischief.

The same is true of advising a resort to surgical measures indiscriminately. The parallel between a diseased uterine and a diseased cæcal appendage is well drawn ; but we all know that the general practitioner has many times succeeded in curing appendicitis without the use of the knife. If we say that his medical cures are doubtful because the diagnosis was not established by exposure and visual inspection of the vermiform appendix, why not apply the same argument to what we believe to be cures of salpingitis and ovaritis without an operation ? What would be thought of the claim that we had not cured a pleurisy or a pericarditis because the diagnosis was not confirmed by an exploratory incision ?

We must not forget that while surgery has given us an inval-

able and a final means of diagnosis in this disease, it has not furnished an infallible nor yet an exclusive method of curing it. For one I regret that the report is lacking in this kind of clinical discrimination. And I also regret that nothing is said in the paper of the essential difference in surgical indications between idiopathic and secondary peritoneal tuberculosis ; neither of the encysted peritonitis of young girls' (Cruvelhier's dropsy) menstrual irregularities ; the peculiarity of the pulse and subnormal temperature ; when instead of a dropsical accumulation there is an extraordinary development of gas ; neither of the judicious trial for a reasonable time of the indicated remedies, with the proper adjuvants of diet, inunctions, massage, and a change of climate, more especially of sea travel, for young subjects before operating. Possibly the use of tuberculin as a diagnostic test might sometimes settle the question as to whether a laparotomy was or was not indicated. And then the value of proper drainage as supplementing the incision should most certainly not be overlooked.

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DR. WALTON said that he was called to operate upon a case which was or had been treated for tuberculosis. This illustrates the therapeutic side. It had been treated for acute tuberculosis of the lungs by the ordinary homeopathic medication and apparently cured. The whole disease then seemed transferred to the peritoneum, and we had that peritonitis which amalgamated the intestines and produced a condition which simulated very much the ovarian tumor which was diagnosed an ovarian tumor ; this was what he was called upon to operate for in this patient. He went into this abdomen with his scalpel and he found that omentum and peritoneum as thickly studded with tubercular deposits as the inside of a bridal couple's umbrella is studded with rice. It was in a fibroid condition ; it looked as though the rice had been poured into that abdomen. That peritoneum was as thick as the double lapel of this coat. He did nothing further in that case but let the air in, and turned in thousands of bacilli hungry to devour just such a case, which are presumed to feed upon tubercular deposits, sewed up the abdomen, and she made a rapid recovery. You may ask, Did not

the internal medication cure this case? I think not; it helped it doubtlessly. I don't think that medication caused the transference of the development to the peritoneum, and I hardly think the peritoneum had the power in itself to rid itself of the tubercular deposit.

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**D**R. W. E. GREEN had recently had two cases of tubercular peritonitis in one family—two sisters. Both patients were decidedly ascitic. One of them was treated by medication, the other one he was called to treat. In his case he did laparotomy. He found both ovaries and tubes degenerated; on either side the degeneration was as large as his fist. The patient had been suffering intensely before this operation; had had no rest without from 1 to 3 grains of morphine at night. After the operation she had no more pain. Within forty-eight hours she said she was as comfortable as she ever was in her life. She recovered and lived for several months; subsequently died from tuberculosis of the pleura. But if for no other purpose this operation was justifiable because it gave that woman relief from pain that nothing before that time could relieve, and if her life had been thus free of pain for but one week after the operation I contend that the operation was proper and justifiable, and it should have been done if from no other point than for the sake of humanity. The other patient suffered intensely and died long before mine did. One of these illustrates surgical, the other therapeutical, treatment.

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**D**R. O. S. RUNNELS said: This is all a new question. It is only in the most recent years that we have grown to know anything about it at all. It was only as late as 1890 that anything appeared in print upon it at all. King brought 131 cases before the world; but now the surgeons know all about it, and others may find it out easily. We are all standing together; we have all got to learn from the very start. You may start very late in the inception of your knowledge, but if you are industrious you will know something about it before you get very far, so that no man need be a bungler always and carpenter at this business. We are becoming so well versed in our education that we can recognize these cases when we see them. Tubercular phthisis is not all there is.

The time to cure consumption was far back in the history of the case; that was the time to recognize the inception of it. Phthisis is curable. Don't forget that. Most of these cases can be reclaimed if we are wide awake and begin early enough.

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**D**R. REUBEN LUDLAM said: This subject has added interest in the fact that three out of five, perhaps, of all the abdominal tumors that we remove—pelvic tumors, too—are tuberculous rather than cancerous, and it shows the importance of this subject that the doctor has brought to our attention. If we operate early, if we recognize it early—these conditions and the tendency early—we can while the disease is localized prevent its development, so that it will not become one of those serious tumors of this fatal class. I hope you will all recollect that on good authority—those who deal largely or wholly in abdominal tumors—that three out of five are tuberculous and not cancerous.

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**T**HE place of electricity in gynecology was discussed by Dr. J. C. Daily. In continuing the discussion Dr. Daily said that when the American Institute of Homeopathy was first organized homeopathic therapeutics was so vastly different, and its application to diseases so infinitely superior, to the old school that the homeopathic profession almost to a man devoted its whole energy and time to the study of materia medica and a mad search for the similimum, and we are to-day reaping, and will ever continue to enjoy, the lasting benefits of their patient study. As the Institute grew, and the number of homeopathic physicians increased, the national body gradually attracted to itself men with the surgical instinct, who, while they acknowledged the power of the homeopathic remedy, saw and appreciated its limitations. This class of men rapidly increased, and the application of antiseptics to surgery has produced such marvelous results that a large proportion of the profession has become enthusiastic on surgery. During the last few years a new Richmond has appeared on the field—electricity; it has been used in medicine from time immemorial, but until recently its use was nothing more than a species of quackery, and this is especially true of its use in gynecology. Thanks to the labors of Apostoli, Englemann,

Goelet, King, and others a flood of light has poured in upon us. We now know that if two poles of a galvanic battery are introduced into living tissue electrolytic decomposition takes place, and that the acids and oxygen are attracted to the positive pole and the alkalies and the hydrogen to the negative pole. The positive pole is hemostatic, coagulating, and sedative ; the negative pole is irritating, softening, and sedative. We know that in the faradic current batteries there is a vast difference in the therapeutic effects of a current from a short thick wire (the current of quantity) and the current from a long fine wire (the current of tension) ; one is the current of volume, the other the current of intensity ; the first produces stimulation, the second sedation ; one acts on the muscles, the other on the nerves. It cannot supplant the knife in lacerations of the pelvic floor and of the cervix uteri, in cancer of the uterus, pus tubes, or in any condition of the pelvis in which pus exists. It is indicated in fibroid tumors, uterine hyperplasia, subinvolution, chronic ovarian inflammation, chronic pelvic inflammation with exudation, in all forms of uterine hemorrhages, in certain forms of amenorrhœa, in endometritis, prolapsus and versions when due to relaxation of tissue, in dysmenorrhœa, obscure pelvic pains, in occlusion of the os and stenosis of the uterine canal, in all forms of hysteroneurosis, and in disorders of menstruation.

Dr. Daily described a case of painful menstruation of ovarian or tubal variety in a lady of twenty ; pain was very severe and generally preceded flow for from one to three days ; worse in region of left ovary. Treated her with electricity until September, when she married. Returned in January with dysmenorrhœa aggravated. Examination revealed an enlarged, sensitive, and prolapsed ovary. The electrical treatment extended over a period of over four months, at the end of which time the patient was discharged cured.

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**D**R. ROBY said : I have had some experience with electricity in various currents in the treatment of a variety of disorders. I have had, perhaps, the greatest achievements and the most satisfactory results in the treatment of uterine fibroids such as I supposed could not be removed with any sort of safety by surgical

operation. I call to mind now a case that gave me a very interesting history. Six or seven years ago I was called in great haste by telegram to the northern part of Kansas, where the patient was supposed to be dying with hemorrhage. Arriving at the house, I found the patient practically exsanguinated, pulse imperceptible; the patient exceedingly pale, feeble, and faint; flowing pretty badly. I made a hasty examination and found a large hard polypus protruding from the uterus. Attaching the *écraseur* to it, I removed it at once, made hot irrigations, and so checked the hemorrhage in due time. The patient recovered health and strength and vitality. A year or eighteen months subsequently another tumor appeared, and the patient, not quite satisfied that I had done the right thing, or that I had done it thoroughly, went to Chicago to Dr. Ludlam, who removed a small tumor, and the lady again recovered for a time; but within another year there came on another hemorrhage as severe as the primary one, and she came to me for operation. I found the uterus very much enlarged—as large as a cocoanut, probably—with what I had every reason to believe was an interstitial uterine fibroid. I undertook to remove it. I chloroformed the patient, but after giving the anæsthetic I made a perfect exploration of the rectum and passed on from the rectum into the region of the abscess, and in the original locality I made out the mass and my heart failed me and I backed out. I didn't remove it. I then told the patient that the best thing I could offer would be the galvanic current, for I believed from former experience that it might at least arrest the hemorrhage. I followed up that treatment for three months, applying the positive pole within the uterus, and the negative sometimes over the abdomen and sometimes over the sacrum. At the end of three months the parts seemed to be practically normal; the growth had shrunk fully one-half in size. She went home and two months later came back and took another month's treatment, at the end of which time the growth had still very greatly diminished, so that it was practically no longer troublesome. She then went to California, and I had a letter from her a few months ago saying that, so far as she knew, she had absolutely recovered. There was no sign of anything wrong. Her age was, I think, forty-two or forty-three. I used the ordinary 10 or 12 cells of the New York Faradic Company's battery. Another case

of a patient in our city who had frightful hemorrhages from a growth of a similar kind. The case antedated this last one. I tried my best to control the hemorrhages. I did not feel at liberty to remove the uterus, which I possibly should do now, and the patient, believing she was about to die, decided to go to Scotland to see them all once more. I gave her a letter to Professor Keith of Edinburgh, who just put her under the galvanic treatment for three months, and in five months she came back to me practically restored. When she went away she was nearly a skeleton, had to be carried to the train ; and when she came back she came well fleshed, good color, and good appearance, and from that day to this she has had little or no trouble. Menstruation regular and normal. Her tumor has disappeared, and there is nothing to indicate that she has had any kind of trouble of that sort. That was, as nearly as I can make it out, an interstitial fibroid. That was my diagnosis. I think I was correct. Professor Keith confirmed the diagnosis, as the report brought back to me showed.

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**D**R. H. TYLER WILCOX said : I wish to corroborate all that I have heard of the essayist's paper, especially as to causing fibroids to disappear that have failed to yield to other treatments. In subinvolution and other kinds of troubles I know electricity is a powerful agent for good. I believe it is the coming agent for many of these cases that were thought at one time incurable. I think it is a potent therapeutic agent that we as yet scarcely understand. We will know it better as we handle it a little more carefully and with a desire to improve upon the old ideas that have been so vaguely afloat touching the sphere of electricity. I have been using electricity in my work for a number of years, and I can speak from personal experience of its great and ever-increasing value in the correction of disorders of my sex.

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**D**R. DELAMATER said : I don't know that it is exactly the thing for a neurologist to undertake to speak on a question of gynecology ; but as I once was a gynecologist in a hospital a little while, I may claim that I belong as a family relative to the bureau. This subject that we have had so excellent a paper upon

is one that is of more than ordinary interest, not so much because it is a new thing, for as long ago as when I first commenced the practice of medicine electricity was used in every branch of medicine almost ; but it is of special importance, I think, because, as the doctor suggests, within the last few years we have just begun to learn something of the A B C, and to know something of its application. It seems to me that the most important objection to the use of it is the fact that we know almost nothing of the physics of the subject ; we know nothing of the thing we are handling. Furthermore, that in nearly if not in most of the methods the few who are scientific in their researches, who are practical in their working out of methods, are giving to the rest of us methods that will be valuable, I am very sure. The application of this must be dependent in each and every individual case the same as in the application of any other remedy, or as in the application of a surgical case ; each and every case must be individualized ; this must depend upon the judgment of the operator, and the judgment of the operator can only be good if he have knowledge and experience.

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DR. L. A. PHILLIPS said : I have just one question to raise on one point in the paper as read, that of applying the cautery to the endometrium as a means of arresting hemorrhage. It seems to me that in a case of that kind as described it was not a tumor ; it was menorrhagia from an enlarged hypertrophied uterus. We have all along had to fight the effects of caustics as applied by our old-school practitioners in many cases to the cervix and ulcerations, and we have found as a result a great many nervous disturbances which are more serious than the local troubles which they are designed to remove or remedy. If the caustic is applied to the endometrium, we get a cicatricial contraction which is more injurious in its general effects than the menorrhagia. In my limited experience I have been able to get equally good results, such as are claimed for the use of electricity by curetting, packing, and stimulating the general circulation to proper action, and promoting by that means absorption or involution, which would compare favorably with the results and in the time named to do it by means of electricity. I would not say it is impossible to use



electricity for any such cases as those without producing such bad results, but I should expect more serious results from nervous disturbance to follow the cure of a condition of this kind and by this means than would be obtained by surgical or therapeutic measures.

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**D**R. A. B. BOOTHBY said : The matter of the use of electricity as presented will bring to your mind the fact that it is quite difficult to determine cases in which electricity should be used and the kind of electricity that should be used, and it is owing to this fact that electricity is doing a great deal of harm. I have just fitted myself out with as complete an electrical apparatus as can be had, and have had it for some little time ; but I am not so enthusiastic in regard to its use as the essayist would seem to imply that he is. It is a fact that the discrimination in which way and the kind of electricity that shall be used requires that the diagnosis shall be correct, and that presupposes that the person using the electricity is thoroughly acquainted with all gynecological expedients and has had vast experience in examinations. It is a fact that those who use the electricity so much are those who are not experienced electricians. In hemorrhage we find that we don't cure our patients ; we let them waste. I don't know whether it is the electricity or what it is, but I have made up my mind that hereafter, when I use the electricity, I will try and use it on my own judgment. Now the statement is made—and I hear it in every article on electricity—that it always cures hemorrhage. We have cases of cancer that have hemorrhage, and it certainly will do harm in that case ; and so the bare statement that it will always cure hemorrhage is not one to accept and act upon invariably.

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**D**R. CHESTER G. HIGBEE said : I want to say a few words in regard to the carelessness in the use of electricity and will cite one case. I was called in consultation with an old-school physician in a small city about twenty miles from our place. He told me of the case and I examined it. I found that without doubt it was an abscess of the ovary or pyo-salpinx involving the ovary also, and that patient was at times unable to

be about ; then it would break and discharge, and then she could move again. I told him to build up the patient and recommended him to use the galvanic current. I told him I didn't expect to cure the abscess, but simply to build her up, and that she would then have to be operated upon. The young lady of twenty-two used to go out with her horse and buggy and go off to a neighbor's to a distant part of the village and get a portable battery which the doctor had left there with another patient, carry it down to the doctor's office, and then he would apply the electricity for a few moments, and the young lady would then take it back to the first place again. Of course, as you can readily understand, that young lady grew steadily worse. In the fall of '92 I was called in consultation, as I stated above, and again in the spring of '93. I built her up again, but that discharge continued and afterward we operated on her.

As to the use in amenorrhœa, I know positively it is one of the grandest agents we have ever used, and recently I have had many cases, some of long standing, one since last August. I always use the indicated remedy as far as I am able to choose it. I have never met with a case of amenorrhœa proper but what I could cure with electricity and the properly indicated remedy. In menorrhagia you must use your power high. My friend Dr. Phillips speaks of the use of the cautery. I do not use the positive current in the uterus in those cases until it cauterizes ; it is not necessary. There you get the allopathic dose in those cases. We don't want it. We want just enough of it to get up reaction. I often only use 4 milliampères in those cases on intra-uterine application of the positive pole. Use your platinum electrodes and 4 or 6 milliampères and you can cure your cases. The great problem in the proper and successful use of electricity is the time that it takes of the physician to apply it properly ; that is the greatest drawback that I know of, and it is a serious drawback. As Dr. Boothby has said, I have tried and do try to make my diagnosis every time before I think of the application of electricity. I do not go upon any one course of treatment every day. I make my diagnosis every time, and I apply my electricity according to my finding, the current, the tire, the tension, and so forth, as I think it best. I do not think

that any routine treatment will do. It will often make your patient worse. I have never cured a patient with pyo-salpinx or hydro-salpinx; but with the use of the proper current, the faradic current, with a general tension for general faradization, I make my best cures and relieve many others. Nor will it cure cancerous conditions. We don't expect it to do so.

\* \* \*

**D**R. JAMES A. WARD said: When so many intelligent practitioners of our school stand before this audience and tell them positively that electricity is efficacious, it must follow that it has a definite sphere—a well-defined sphere. I have closely watched the cases that were placed under electrical treatment for several years, and have come to the conclusion that electricity is good only in functional diseases of women on the line of dysmenorrhea. We know how it can be of service. When Howard Kelly left the Baltimore University only a few weeks ago and went before the State society for one single purpose, and that was to call their attention to the subject of dysmenorrhea and discuss its origin in the troubles of the tubes and ovaries, there is no doubt that electricity is of value if judiciously applied in functional troubles of women; they can be arrested, these troubles. Yet the homeopaths cure every day cases of this kind with the indicated remedy. Dysmenorrhea, then, has its decided origin in troubles surrounding the uterus, for when you have passed a sound with very great difficulty into the uterus your patient has not complained at all; but let the slightest trouble afflict a tube or that ovary and you will also have the dysmenorrhea; this would seem to indicate a congestion and inflammation of the mucosa. Amenorrhœa is functional very often. So far as subinvolution goes, it, again, is a functional trouble in its early stage, while, if the engorgement is toward the involution, we have the trouble arrested and thereby relieved. Who has ever opened an abdomen and removed through hysterectomy a large fibroma, and opened that structure and found it cystic, and could think that electricity could do for one moment the slightest good in the way of absorption of that growth? There is great danger in electricity. Those who open the abdomen frequently find that there has been so much gynec-

cological tinkering, and it comes mostly from the use of electricity; the peritonitis is oftentimes very extensive, and the very worst cases of hysterectomy that we have had to perform have been those where there has been complications produced by a pre-existing peritonitis brought on by the injudicious use of electricity.

\* \* \*

DR. REUBEN LUDLAM said : It has been claimed here that electricity removes fibroids. Cases have been cited, giving the size and bulk and all that sort of thing. There are many other cases that result in diminution of fibroids under certain conditions, there is no doubt about that. I think I have been in attendance upon Apostoli's clinic twice. On two several occasions, and for a considerable time, I have been in Apostoli's clinic. I have seen his cases day after day. I have studied them through a son of mine for three and four months at a time. We never saw a case of fibroid the size of which had diminished by the use of electricity. They did subside a little, and then they grew again. Two doctors examine a patient, and they will give you a very large difference in the size of the fibroid. Another thing ought to be borne in mind, and that is that it is extremely rare for a fibroid to exist single and alone if it is of considerable size. And when one is told that a fibroid in the center of the abdomen has shrunk, you should remember that in all human probability in that abdomen there are a number of satellites. This one has stopped growing, but others are growing below. Only a little while ago I removed a very large fibroid weighing thirty-six pounds, which had been treated in a sanitarium for two and a half years by parties who I know are experts in electricity. At one time the fibroids diminished, and he thought it was going to disappear. Then it grew a little. Finally the patient's health failed, so that the removal of the fibroid was determined upon, and there were nineteen others. They were practically out of sight, and the first one was undergoing a sarcomatous condition which usually follows the climacteric. The climacteric, instead of electricity, results in the diminution and disappearance of fibroids in the majority of cases. Degenerations of whatsoever sort go down then very rapidly as the uterus

shrinks and becomes atrophied ; so the vitality of these tumors being cut off, the tumor itself is destroyed—they are of very low vitality anyway—and they begin to undergo degeneration. They ought to come out then. I believe that electricity at this time often does an immense amount of mischief in deferring the time of the operation which will be inevitable and absolutely necessary. I think that the consensus of opinion as to fibroids is this : That unless the fibroid is hemorrhagic, unless it is single, the electricity will do nothing more for it than to relieve the symptomatic indications and sufferings which the patient has. If it is hemorrhagic, then the electricity may be used with benefit ; and if the fibroid is single it may be used for a time.

\* \* \*

DR. F. G. COMSTOCK said : I have had something of the same experience as Dr. Ludlam. I had the benefit of Apostoli's instruction, not only in his clinic, but privately, when I was in Europe four years ago. I saw a great many of his cases. I saw French women operated on with electricity in a way that American women would never have endured in the world. I was there some six weeks, and I must say that I didn't see one cure. It might have been my fault. When I returned from Europe, I fitted myself up with electrical appliances, and I had a little experience with it. I can't say that I had any very great success; but I simply rise now to ask the essayist and the electricians present if they don't know of many cases where electricity has done harm. I have heard personally of a good many cases where it has done harm.

\* \* \*

DR. ROBY said : Two years ago, at the meeting of the Institute, I reported a case of uterine fibroid which weighed thirty-six pounds, and since listening to the narration of these cases it brings to my mind some facts that I wish to state in reference to the use of electricity. This case had been in the hands of a physician who thought he knew a good deal about the use of electricity. He had applied the faradic current, the galvanic current, and the combined current for a considerable length of time, and yet, while the hemorrhage that was in the case had disappeared, the growth itself—the neoplasm—continued to en-

large, until the lady was becoming so burdened with the weight of it, and the enlargement was so great and the abdominal viscera was so crowded out of place, that her respiration became difficult and labored and circulation interfered with very much. Finally she came to me for an operation and I removed a thirty-six-pound growth. In this case the electricity had done nothing to arrest the continued growth of the neoplasm. I do not use the current strong enough to produce cauterization at all. I use only such degree of strength of the current as was most easily borne without pain or discomfort to the patient. In the case that I sent away to Professor Keith he used the Apostoli method. In my own case I simply passed the electrode into the uterine cavity and applied just such current as was easily bearable to it. I have never treated a case with puncture.

Drs. Higbee and Boothby declare that the use of electricity in fibroids has been disappointing.

\* \*

DR. DAILY closed the discussion by saying: It takes diagnostic skill to use electricity just the same as the surgeon and the general practitioner require diagnostic skill. No one can use electricity by taking it up. I am not an expert in it by any means. It is a great big subject to handle. I never had but one case of fibroid. In that case I only produced a symptomatic cure. It very often does control the hemorrhage of fibroids. In regard to the statement of Dr. Phillips in reference to cauterization, I will say that I have never known those reflexes to follow. I do not apply the cautery to the extent that his remarks would indicate, and I therefore have no such cicatricial contractions to deal with as he has mentioned.

\* \*

DR. CHARLES E. WALTON read a paper on "Cystospasm" which was discussed by Dr. A. L. Monroe, who said: I have had a good deal of that sort of trouble to contend with, as I suppose all have who practice gynecology to any extent, often having an irritable bladder following operations on the rectum or the uterus, or the removal of caruncles, or what Dr. Walton called urethral hemorrhoids, for such they are. And I have had a great deal of

worry in a good many of these cases which were persistent and troublesome. They would send for me in the middle of the night to use the catheter, and if I can save any of you a little of that trouble by my experience I will be glad to give it. One of the measures I resorted to is to wash the bladder out with a solution of boracic acid. You can easily teach the attendant or a friend to do that. Another remedy that is not thought of by all physicians is hyoscyamus after cannabis and cantharis and aconite and alumina and nux have failed. Often 10 drops of the tincture of hyoscyamus or of the first will relieve those spasms very promptly. Another thought in this connection—that many of these cases are due to a bad liver; the kidneys are doing some of the work that the liver ought to be doing; the urine is not natural; it may be caustic in its nature; it may be too alkaline or too acid, so you had better test its reaction to see if it is acting as a local irritant to the bladder and urethra, and you will have to use some measures to relieve that unnatural condition. I have used the effervescent lithia tablets, and have had them relieve the condition in twenty-four hours.

\* \* \*

DR. GROSVENOR said: I have just been having the rather sad pleasure of caring for dear General Trumbull in his last illness. He had had for eight years a trouble with his bladder, with this cystospasm every half hour; but in his case there was such positive disease of the bladder and renal structure that that accounted for it. On his demise we made a *post-mortem*, and we found the bladder wholly non-distensible, thickened, corrugated, ulcerated, so that that might account for the trouble that he has had in the last few years. We went further, however, and removed the kidney, and found in the pelvis a stone as large as my thumb. I had sounded for stone and had found none, but when we examined the bladder we found two not larger than pin heads; but the one in the kidney was as large as my thumb, every bit of it. In his case we found great relief from irrigating the bladder with listerine, taking a dessert spoonful of listerine to a cupful of filtered boiled water, and that gave him more comfort than anything else that we used. And in irrigating the bladder I used to do it twice a day. For four years he had to have his water drawn two or three

times a day. In irrigating the bladder we have simply taken a soft catheter, attached it to a tube, and siphoned it up and let him pass it off himself.

\* \* \*

**D**R. SANDERS : It may be regarded on the part of the members of this section that I am presumptuous in speaking, as I am not a gynecologist, but I want to raise the question, How much of medication had been resorted to in this ?

Dr. Walton : Five years of medication.

Dr. Sanders : I had one case not, perhaps, so persistent as this, but very much like it in all its phenomena, all its distress in the disturbance of sleep and in the suffering in the daytime ; it was a case that had long been medicated by allopathic measures, by homeopathic therapy, and by some hook or crook came into my hands. I made a careful examination ; I could find nothing but the bare fact of the irritability of the bladder from the fact that there was a quality in the urine that had a little whitish appearance that hadn't been taken notice of by anybody else ; it had been of three or four years' standing, and just a few days' treatment with acidum phosphoricum 2d cured the case. I have had other experiences wherein we have had the same thing—cystospasm, irritable bladder—where it depended upon an unsuspected and yet a delicate leucorrhœa ; yet the quality of that leucorrhœa was so irritative it would come down and be taken up by capillary attraction into the urethra. That case and others like it would be markedly relieved, perhaps, by the indicated therapy. But there was no cure by any vaginal douches, only temporary comfort ; but on treating the leucorrhœa and the endocervicitis upon which it depended, the case was cured. That has been my experience with a great many of these cases of cystospasm.

\* \* \*

**D**R. REUBEN LUDLAM said : I suspect that there was sugar in the urine of Dr. Sanders' case. I have cured three of such cases on the theory that they were diabetic, having found traces of sugar in the urine. There is a class of cases of this sort because there is no more distressing affection surely—I am sure this is an invention of the adversary—not only to torture the patient, but also the doctor. One of the best means of relief that



I have found as a temporary shift is to seat the patient in warm water and leave her there as long as she pleases to stay, one hour or five at a time, and in this way get the only relief she had had for days and weeks. That case went on and developed finally as these cases usually do, and as Dr. Walton's case did. The outlook for such cases is not very good when you can't find any reason for the existence of the symptoms. Many of these cases will turn out to be tuberculous. There is an expedient for this which is remarkable in the relief it affords. Everybody knows the effect of lactic acid upon tuberculous growths and formations. So the simple injection of warm milk into the bladder will do more good to the patient and put her on a more comfortable basis—for we don't expect to cure them—than anything else that I can now think of.

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**D**R. GEORGE ROYAL said: This is not purely a neurosis. I think Professor Ludlam's idea the better one. Now to illustrate a case of my own: Twenty years ago a lady gave birth to her only child; following that there was a good deal of laceration lasting all through her life for eighteen years, and it had been pronounced a neurosis. They had tried electricity and everything else. About two years ago the lady died of abscess of the spleen. We were not quite sure of the trouble or where it began. We went on down and examined the kidneys; we found there a whole handful of these stones, and one of them was three times as large as a cherry stone, and, as Professor Ludlam suggested, such cases will come back to you, even if you give them temporary relief.

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**D**R. ROBY. I have had good results a few times in similar cases by dilating the urethra very widely, then following it up with benzoic acid, and this is a good remedy in a good many cases of irritable bladder. I use it sometimes as a wash, but most frequently internally, the 2d or 3d.

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**D**R. LIZZIE GRAY GUTHERZ read a paper on "Woman's Steadfast Friend," which is printed in another part of the JOURNAL. In discussing it Dr. A. L. Monroe said: I have been halting between two opinions, but, as I said before, we can take a

few liberties with our friends. I have studied *materia medica* with a fair degree of industry and a great deal of interest for about eighteen years. I have taught *materia medica* for four years, but I must say in all candor that the indicated remedy has its limitations. I want to speak upon this subject, because I don't know of any other man in the Institute who has tried to straddle such a big fence as when you make a specialty of both *materia medica* and gynecology. I tried to cry down the gynecologist and surgeon, and I found that when I healed the cases of gynecology that came to me with a dose of *pulsatilla*, yet in a month or two they would come back and get some more. Sometimes I would get a very brilliant cure out of a case that was neurotic; but where there was stenosis, and where there was metritis, where there was a plug in the cervix, where there was a hooded constricted clitoris, where there was a diseased rectum, you may defy mechanical laws, but you cannot cure that patient by internal treatment alone. I would now just as unwillingly let go of my surgery as I would of my *materia medica*. I don't want to go to either extreme; *materia medica* helps us both ways, before and after. Use both with discretion.

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**D**R. ROBY. We must not become extremists. It all comes to a question of diagnosis as to whom the case properly belongs—the surgeon or the *materia medicist*. All cases of a certain type, or at least a very large percentage of them, I believe by careful and proper study may be classified as they occur to *materia medica*. There are certain conditions where medicines are absolutely powerless, there are cases where the knife is absolutely powerless, and there are cases where they are all-sufficient. It is a fact that *materia medica* can help out the knife when the knife has done its work and has done what is required of it; then the *materia medica* can come in and help to restore the physiological disorders after the cause of the disorder has been removed by the surgical procedure.

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**D**R. PRATT said: There is just one thought that I want to state in relation to the male sexual system; in this case the urethra and the sexual apparatus are together and the troubles have their

origin in the prostatic. In the female these same organs are divided. What is the point of the penis in the male is the clitoris in the female, and just as prostatic trouble in the male will cause all bladder troubles in the male, so you will find the common bladder troubles in the female accented or emphasized in the hood of the clitoris or in the condition of the internal os. It operates in both cases by a series of reflexes. The cause of a man's peculiarities may be the club he belongs to ; but if he is a happy man it is because he is perfect in his sexual system. But when the rectum is wrong, then the trouble is in his own family. If the woman is unhappy, it is in the clitoris that the trouble must be looked for, or in the internal os. You must look for the lacerated os and the cicatricial formation in that os, that you cannot see without looking very carefully for it.

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**D**R. L. A. PHILLIPS said: I fully indorse the early examination recommended by several of the speakers and also the essayist. Gynecologists are accused of being too anxious to make examinations. Nothing is so important in woman's disorders as to make an examination and know where we have pathological conditions which require surgical aid, or whether we have neurotic conditions, or those which can be made amenable to therapeutics.

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**D**R. GUTHERZ, in closing the discussion, said that she remembered reading of a little man who could not see very far until a giant took him on his shoulder ; then he could view the country over and describe what he saw. Dr. Guthertz thought she was somewhat in this plight, and that Hahnemann was her giant, and from his shoulders she could see farther than the gynecologists could who only gave their attention to the surgical part of their profession.

# THE HOMEOPATHIC JOURNAL OF OBSTETRICS, Gynecology and Pedology.

EDITOR, GEO. W. WINTERBURN, M. D.

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## TECHNIQUE OF IMMEDIATE PERINEOR- RHAPHY.

BY

SHELDON LEAVITT, M. D.,

CHICAGO, ILL.

I SHALL concern myself in this paper only with the method of immediate repair of incomplete laceration of the perineum. Complete rupture is relatively rare, and an operation involving fine and exact technique is required for its repair. I have never seen a case of the kind in my own practice, and have done the operation but a few times for others. Be it understood, however, that I do not share the conviction which accounts it wise to defer operative procedure in such cases, though immediate suturing in a way as to insure complete restoration of the part is no easy task.

I have long been convinced that the results of immediate perineorrhaphy are more unsatisfactory than they need be for the reason that the common operative

methods are imperfect in detail. In several instances I have had occasion to examine women within a few hours *post-partum*, upon whom the operation had been done, and in every instance was able to thrust my fingers into the wound upon the vaginal side. In more than one instance, after closing similar rents myself, in accordance with usual methods, introducing sutures from the integumental surface only, I have been surprised to find, when I supposed close apposition had been obtained, ample room upon the vaginal side of the wound for easy percolation of lochia into the wound cavity.

In fact, I have long since ceased to wonder at the few real successes attending this operation in the practice of the average accoucher. On the contrary, I am surprised that fair results so often follow what is usually imperfect work.

In order to restore the perineum to a condition approximating its original integrity, careful coaptation and close stitching, especially within the vulva, are essential. In my opinion the weakness of such operative work is chargeable to the inexact manner in which it is usually done. The first segment of the hour immediately succeeding delivery is unfavorable, I admit, for deliberate and painstaking procedure; and a stern sense of duty to the patient alone is capable of impelling us thereto. After delivery, the patient and her friends are prone to settle themselves into the comforting persuasion that the crisis has been passed, and that the suffering of travail is ended. To break rudely in upon such serenity and trust is not a pleasant duty.

The question of anæsthesia is one which requires to be settled in each individual case. If labor closed with the patient in a state of obstetric, or incomplete, anæsthesia, prolongation of the condition is advisable. If there has been surgical, or complete, anæsthesia, owing to operative interposition, sensation will be restored with such tardiness that repair of the torn part can be made without further

exhibition of the anæsthesia. But we have cases, and they are by no means rare, in which delivery terminates without the use of anæsthetics, among which we would include those of precipitate labor. To determine the advisability of anæsthesia among such requires nice discrimination. Women of a phlegmatic temperament will sometimes bear the pain incident to a rapid introduction of the necessary sutures with remarkable fortitude; while others become demoralized by the mere suggestion of such a proceeding. It is sometimes wise to cover the torn surfaces for a few moments with a strip of gauze wet with a strong solution of cocaine, the effect of which nicely supplements the benumbing influence of pressure and distention which prevails for some minutes after fetal expulsion. Other cases require a general anæsthetic.

It is my custom to wash and disinfect, during labor, the instruments which are liable to be required for making the repairs in question, namely: two artery forceps, two full-curved needles about an inch and a quarter in length, needle forceps, and scissors. One of the needles is threaded with catgut about sixteen inches long, and the other with silkworm-gut. I also lay out a leg brace for maintaining the lithotomy position, which I always carry in my bag. I do not now use the long perineum needle, with fixed handle, so commonly employed for introduction of wire sutures. Beginning at the upper extremity of the vaginal wound, and the posterior extremity of the integumental wound, I put in uninterrupted sutures, both lines of sutures terminating at the vulvar commissure (Fig. 1). At the latter point I sometimes put in a stitch or two of silkworm-gut. I am partial to catgut for this operation, inasmuch as use of it obviates the necessity for subsequent removal of the sutures. Nos. 3 and 4 are the preferable sizes.

The method of sewing is well shown in the accompanying cuts. The thin edges of the torn vulvar commissure are seized with artery forceps and downward traction made. This straightens the wound and gives its precise form and

size along the vaginal surface (see Fig. 2). It is plain that this preparation makes perfect suturing a matter of ease. Ordinarily these sutures need not be deep; but when the rent penetrates to a great depth in a thick perineum, they should take a good hold of the deeper tissues. Finishing this line of sutures at the commissure, the thread is tied, and a new line started at the anal extremity of the tear, the needle entering from the integumental surface. Introduction of these sutures is facilitated by forward traction on the forceps (see Fig. 2). These stitches should take a deep hold of the tissues, so as to insure perfect contact of the opposed surfaces. This line of sutures also terminate at the commissure, the very edges of which should be perfectly united.

I have tried various methods of immediate repair of the torn perineum, and this is to me most satisfactory.

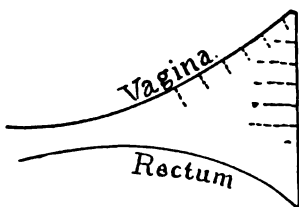


FIG. 1.

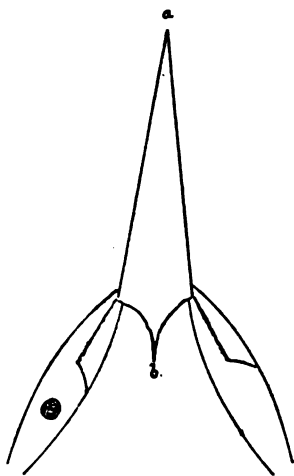


FIG. 2.



FIG. 3.

## THE FEEDING OF SICK CHILDREN.

BY

B. H. B. SLIGHT, M. D.,

NEWARK, N. J.

"THERE aint hardly nothin' a 'l'phant can't do," said the little boy on his return from the circus after dilating upon the proceedings there, and "there aint hardly nothing" some children can't digest and live through, while others are cut off in a minute. "Come just as quick as you can, there's a woman got the cramps," was the early morning message which appealed to my humanity and brought me to the bedside of a burly Polish Jewess. Some four or five months later when I called to inquire about the baby's welfare, and, incidentally of course, to collect some "shekels," the mother told me the child ate cabbage and meat and drank coffee and beer. "Why," I shouted, "do you want to kill the baby?" "Pring down dot kilt baby," said she to her ten-year-old hopeful, who in due time brought in a baby which looked a year old—dirty and fat. "Wie is dot for a kilt baby? Dot baby she cry oud if you don't gif her pier und coffee und cabbage w'en we eat our dinner; dot baby she don't die so easy." That baby is not among "the good who die young." Children who have not inherited ostrich stomachs, however, are the ones who must claim our attention.

The best efforts we make are often thwarted by the injudicious kind-heartedness of aunts, grandmothers, and other good, but not wise, attendants. If you have a convalescent who has a relapse don't neglect, if there is a busy-body of this kind in the house—permanent or transient—to closely question her on this topic; *she did it*. There are many people in this world who believe in eating to



such an extent that they cannot forbear to feed the sick, the tired, the overheated, and the convalescent to the extent of poisoning them.

Children are so prone to overeat that when they become sick it is safe to cut off food almost completely for the first few days; then a light diet—cereals, milk, broths, etc., and no knickknacks—is in order.

A word as to cereals. Let their cooking begin the day before; then there will be no uncooked kernel to scratch the delicate mucous membrane. These largely advertised "fifteen minutes to cook 'em" cereals are simply devilish, an injury to man and child.

Many children whose parents think them possessed with worms, while their school-teachers think them possessed of a devil, have a tortured mucous membrane about thirty feet long, and a tortured sympathetic nervous system miles long. They bite their finger-nails by day, are animated stoves by night, and bawling, nervous, *sick* children all the time. (If the average factory girl knew how to cook, temperance and good morals would receive a grand impetus.) Kill off the tuberculous cows, keep the rest in clean, wholesome stables and yards, and much would be done toward conserving the babies who now die off so alarmingly before their twelvemonth of existence.

Take away from the child of from three to twelve tea, coffee, and pungent, spicy, and ill-cooked diet, and in happier homes healthier children would flourish, the doctor and undertaker being far less in demand.

Millions of people live on rice, which is as nourishing as bread or meat, and this American people could do likewise with advantage, especially as to the feeding of children. Rice water, with sometimes the white of an egg in it, should often replace milk. No curd forms from it, no tubercle raises its horrid front. Speaking of curds leads me to say this: When a child's throat is sore you inspect the fauces with care, and you do well; but quite as often

the other end of the *prima viæ* needs your attention, for there disease lurks even as in other corners of the anatomy. All hail, Pratt! I hold it unfortunate that there are physicians who so frequently prescribe alcoholic stimulants that habit leads them to recommend them for children. I say habitually, for, though I have not the courage to be a temperance crank, I am at a loss to perceive the line of argument which would lead a reasonable man to take the risk of fostering—nay, creating—an appetite for strong drink in a child. I am aware that this is not a scientific article, hence I must apologize for it; nor have its “points” been culled from books read, “many a time and oft,” by the members of this institute; such and few as they are, they come from observation among children whose deaths so alarmingly swell the mortality statistics.

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## NEURASTHENIA OF CHILDREN.

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BY

E. N. CHANEY, M. D.,  
CHICAGO, ILL.

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**D**URING the past few years several interesting cases of children's diseases have come under my care. The hygienic treatment has been an important factor in aiding the similitum in the cure of these cases. As I desire more information on this subject, and believing that others need help along the same line, I submit this topic to our worthy chairman on pediatrics for consideration and discussion. General functional neurotrophia is manifested in many ways—by derangement of the alimentary canal, lesions of the respiratory tract, impairment of the urinary organs, malnutrition of osseous structure, inertia of striated and non-striated muscular fibers, derangement of skin func-

tions, etc. I will not enumerate the long list of trouble engendered by impairment of functions. You are all acquainted with them, or should be. The initial cause of these irregularities are exposure to weather, indiscretions in diet, traumatisms, and persistent dosage with nostrums. Neurotic conditions are the legitimate offspring of lesions located within the orifices of the head and lower part of the body. In the child the rectum and foreskin furnish trouble in abundance.

In regard to the nerves let us consider their anatomy, physiology, and pathology. We find the organs in the orifices connected more or less with all the organs of the body by the cervical, solar, hypogastric, Auerback's, and Missner's plexuses, the lateral chains, pneumogastric and splanchnic nerves.

The mission of the sympathetic nervous system is to regulate the heart's action, induce respiration, promote gastric peristalsis and peptic secretion. The great sympathetic system, aided by the cerebro-spinal, operates with clocklike precision the capillary circulation, glandular secretion, and controls the muciparous secretion and also the aggregated functions of the reproductive apparatus.

Neuroses are due to various causes, and present themselves in great array, as hysteria, epilepsy, insanity, and finally apoplexy. With the respiratory organs, asthma and other neurotic exhibits. The heart with its palpitation, its valvular irregularity, fatty degeneration, etc.; and so on, all the vital organs with their outbursts of distress.

Possibly the action of homeopathic remedies works favorable results in the field of therapeia by setting aright nerves which are at sixes and sevens.

If nerves are pinched and become dormant they cannot evolve wholesome stimuli, and medicine can exert but little favorable effect on the parts they are deputized to govern and operate.

If the initial cause of a trouble is speedily found medi-

cine called into use will usually be sufficient to establish a cure. Should, however, the illness continue, not yielding to the indicated remedy, search for cause of the reflex trouble. If there are irritations found in the male generative organs free the foreskin of all adhesions and smegma and cut frenum, etc. If the trouble is in the bowel the sphincters will usually be found abnormally constricted, and my way is to relax them by dilatation with a speculum or conical dilator. This flushes capillaries by abating the compression of ganglionic nerve filaments. A small rectal injection of peroxide of hydrogen, or any other non-toxic, antiseptic solution, may be used to maintain a healthy condition of the bowel, and the sphincters may be rendered soft and pliable by lubricants of vaseline, lanoline, etc. If impaction of the bowel exists a cup of sweet oil, followed with large quantities of warm water per rectum, may be injected. The following cases are given to illustrate the above thoughts. The first three cases might, in my estimation, have been saved had I looked for the cause of the reflex phenomena, and instituted proper treatment.

CASE I. April 28, 1892. Was called at 8 A. M. to see baby S., age one year. It was found in a convulsion one hour before. Everything that the parents and neighbors could do to revive it had been done to no effect. The child had been pale and peevish for several days, but no trace of worms had been seen. I called several times on the little one during the day. It moaned, clenched its fists, with now and then a spasm. It received cham., cina, ipec., ign., and opium in different potencies, with no benefit, while an increasing prostration ensued. It died at 9 P. M. the same day.

CASE II. July 14, 1892. Baby G., age four months, had what I diagnosticated marasmus. When first called I found the infant quite emaciated, pale, pupils contracted, weak and rapid pulse, dyspnœa—in fact, I thought the little patient moribund.

Opium 12x was administered, which proved effectual for only a few hours. Several other remedies were given at different times with about the same effect. It succumbed July 28, 1892.

CASE III. August 24, 1892. Was called to baby D., age three months. Had a temperature of 104° F., rapid pulse, colorless, thirsty, moaning, vomiting, and purging. Had been ill about one week.

Gave ver. v. 30x, followed by ars. m. in three hours. The child improved steadily and enjoyed a fair degree of health, when, September 3, 1892, it was suddenly seized with symptoms similar to those of last attack. It received ars. high and low without good effect, the baby living only an hour after I arrived.

The treatment of the following cases was attended by success, on account of addressing myself to the reflex cause, while at the same time I employed the similimum for each case.

CASE I. Baby S., sixteen months old, has had several convulsions the past two months. March 26, 1893, gave cina 6x for its worm symptoms.

The next three days it passed masses of mucus and ascarides, which gave partial relief, but the seventh day the child experienced the severest convulsion of all, and did not rally immediately. The parents had lost a child a year or two ago in the same manner and were naturally anxious about this one.

I arrived about half an hour after the spasm. It was in collapse, the pulse thready. Introduced a bivalve speculum to the rectum at once and made one dilatation slowly and the baby responded with flushed cheeks and a cry, was soon active with an improved pulse. I discovered a number of inflamed rectal pockets and ulcers during the dilatation. A few dilatations and hygienic treatment, with now and then a few doses of cina or cham. improved the child's health. It has had no convulsions since the first dilatation.

CASE II. September 23, 1894. Baby P., two years old, had been suffering with whooping-cough for three weeks. One morning the dyspnoea was so aggravated that the parents tried to relieve it with castor oil and glycerine per mouth. About twenty minutes later the child was in convulsions. They resorted to massage and baths without success.

Upon arriving I found all the muscles rigid, eyes set, breathing oppressed, loud rattling in the bronchi, and teeth clenched so tightly that it was difficult to give medicine. I dilated the sphincters and this was effectual. As the muscles relaxed, the breathing became more normal. The child opened its mouth and cried vigorously. Gave tart. em. 2x. The case made a rapid recovery.

CASE III. I introduced baby B. to the world July 28, 1893. It was only two weeks old when taken with vomiting, rattling of mucus in bronchi, green stool, temperature 103°, thirsty and very fretful. Ipec. relieved. (A few years previous to this baby the parents lost two children when only a few weeks old with the same symptoms.) October 27, 1893, was summoned again for the same trouble, except stool was watery and the child quite prostrated. Ars. mm. allayed the symptoms till December 8. At this time it had chills and fever, constipation, vomiting, insomnia latter part of night. Nux v. helped slowly. January 27, 1894, the baby's illness became more serious than ever, with chills and fever. I then looked for the reflex cause and found the sphincters tight and rigid. Employed juvenile speculum and moderately used the indicated remedies, ars. and nux. v., at different times. Discharged the baby as cured February 6, it being the first day since birth that it nursed regularly; slept peacefully, bowels were normal, happy disposition, and to all appearances well.

Since then the little one has grown fat and healthy, without a sick day. The local treatment will be employed once a week for a few months to insure a normal condition of the bowel.

CASE IV. Baby L., nine months old, has been treated for four months by physicians of both schools for "indigestion and kidney trouble." November 28, 1893, it was first brought to me suffering with an acute attack of vomiting and purging, quite thirsty and prostrated, for which it received ars. m. with some relief. December 1, was called and elicited the following information: No appetite, profuse salivation, neck emaciated, skin dry and checked, anus and vulva fissured, bowels constipated and inactive, and scant urine six to eight hours.

Natrum mur. followed by sulphur. Here again I employed dilatation of the rectum for four weeks, which left the orifices in good condition, the skin soft, and excellent appetite. Teething then set in, which took but a short time, but with some worrying that was relieved with cham. 6x. It has had no medicinal care for several months and still continues well.

CASE V. February 5, 1894. Was called in haste to see a little girl, two years old, who had been ill for six weeks, attended by a regular. She had been failing slowly and was reduced to a skeleton. I found her moaning, very thirsty, had not eaten a cup of food for five weeks, so prostrated that she could not raise up or turn over, bowels moved only a little every four or five days, and abdomen hard and distended. Immediately dilated the "inch." Prescribed sweet oil injections for three days. Ars. mm. in water was taken and an injection was given that evening.

The next morning I was surprised to find the little one sitting up in bed devouring a cup of granum. She then took cina 6x a few days, which was her last remedy.

After the injections she passed large quantities of dark, dry, hard stools followed by mucus. Rectal dilatations and peroxide of hydrogen injections were employed for weeks. Four days after the first injection she passed a large mass of blood and mucus containing a date stone, which the parents think was swallowed five weeks before. February

11, found her recovering so rapidly that she was discharged and to-day is hearty and strong.

The following case, although a child is quite an old baby for this list of cases, but being a typical illustration and conformation of my theory I could not refrain from using it :

CASE VI. April 14, 1893, called on Edith F., age ten years, who complained of severe headache worse on motion, no appetite for several days, thirsty, stools dry and hard, bowels inactive, temperature  $103^{\circ}$ . She received bry. 3x followed by three powders of bry. m., which relieved her partially. She also complained of a catarrhal discharge from the nose, which ceased when she had a fever, and started again after this attack. Much time and money had been spent with no favorable results. July 10, 1893, her temperature rose to  $104^{\circ}$ , accompanied by symptoms similar to those of last attack.

I examined our patient for reflex trouble and found a tight sphincter and slight ulceration of the last inch of the bowel, which I treated similar to the above cases and repeated the bry. mm.

Three weeks after the first local work her mother came to the office one morning exceedingly joyful to tell me that her little girl had not been troubled with the catarrh for some time. I advised the treatments continued once or twice a week for a few months, and she is still improving.



## PREVENTION OF DEFORMITIES.

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WE read that God created man in his own image, and we conclude that he was in the beginning of perfect form. Then environment must have been responsible for the imperfections which gradually developed. They have existed and have been treated since an early period, as we learn from medical literature. Hippocrates wrote a treatise on articulations in which he taught the proper method of bandaging in cases of infantile deformity of clubfoot. Celsus described the radical cure of hare-lip. Professor Andry of Paris first arranged all deformities under one head. He tried to find out their common causes, and establish general principles and indications for their efficient treatment. His publications appeared in 1741. Stromyer in 1830 first performed subcutaneous tenotomy for the relief of clubfoot.

Diffenbach and Langenbeck in Germany, with Bonnet, Guerin, and others in France, labored to develop scientific knowledge and orthopedic surgery. In England Dr. Little was the pioneer. The subject of congenital clubfoot himself, he could understand the demand for correction of the deformity. His efforts and energy gave London the Royal Orthopedic Hospital. America was not in haste adopting specialties in medical science. In 1834 Dr. David L. Rogers first performed tenotomy in this country. Detmold, a pupil of Stromyer's, in 1837 introduced among us subcutaneous myotomy. In 1842 Dr. Valentine Mott published the result of his studies while a pupil of Guerin, and with great enthusiasm announced his intention to found an orthopedic hospital in New York. His life was not spared to

accomplish his purpose. Dr. Henry J. Bigelow of Boston published a work in 1845 on orthopedic surgery. In 1876 Sayre gave the world his book on the same subject, which was so favorably received. He recognized that orificial irritation was a source of reflex nervous contraction. Since that time orthopedic surgeons have increased yearly in numbers and ability, until to-day every great medical center affords specialists and hospitals where a multitude await their skill in the use of the knife or some mechanical device for correcting deformities. The development of surgical science in the past ten years has enabled surgeons to relieve many a deformity that in earlier times was considered irreparable. We find in one of the latest publications on surgery that deformities from non-development are only of interest surgically when some apparatus may be applied or some operation performed. But to the mother of a deformed child and to the victim there is an interest beyond the brace and knife, an interest which desires for all others exemption from his fate. We should be swept aside by the tide of progress did we not join the clan who see in the future most hope from the department of prophylaxis. Hence to-day we ask you to consider not only the distinguishing features of disease and the best methods of treatment, but can we, and how can we, prevent the occurrence of deformities? It is a law of heredity that deformities commonly reappear for four or five generations, and are seldom altogether eradicated in less than ten or twelve. The members of this organization know that suitable medication gives us brighter prospects. I will first mention the deformities of most frequent occurrence with the causes assigned. Hare-lip and cleft-palate are classed as non-development from failure of the mother to properly assimilate phosphatic elements of food. It is generally conceded that the same causes producing rickets are at the foundation of this trouble. Spina bifida is also due to similar conditions. Imperforate anus or vagina, anomalies of ears, nose, and

teeth, all show faulty development and are of intra-uterine origin. Monstrosities, having absence of brain or skull, or with hernia of brain substance, are deformities resulting from disease of the nervous system beginning during intra-uterine life and rarely survive.

Genu valgum, or knock knee, and genu varum, or bow legs, are of rachitic origin. Pigeon breast, barrel-shaped breast, and flat chest also are deformities of which rachitis is attributed the predisposing condition, but they are acquired after birth. Intra-uterine amputations and congenital malformations which closely simulate fracture are said to be caused by amniotic adhesions during the first and second months of intra-uterine life. To those who know of the numerous attempts to destroy the product of conception at this period of pregnancy it is not surprising that adhesions exist. If every attempt failed, and adhesions followed producing these deformities, some neighborhoods would need more than one hospital for cripples. No one can read Hugo's description of the cruel practice of severing muscles which resulted in the deformity of "the man who laughs" without a chill of horror. But the one who aids in removing the uterine contents at this period performs a deed less humane. He ends a life, or, when failing in the purpose to destroy, causes ill health of the mother and deformity of the child. Often its physical body is less maimed than its mental and moral condition. Paralysis cause lamentable deformity. The promontory of the sacrum, or the ischiatic spines, may make pressure upon the skull during delivery which will result in facial paralysis. The seventh nerve being injured at the point of exit by the forceps produces this marked deformity. Pressure on the brachial plexus during delivery may later develop infantile paralysis.

Spinal curvatures are acquired deformities. Lateral curvatures are most common, and are generally attributed to muscular weakness and bad position in standing, sitting.

or sleeping. A recent article by an able authority considers this deformity of nervous origin. In discussing the subject he says: Lateral curvatures are among the deformities most frequently met with, and at the same time most disastrous in their effect on the development of the human body. Their causes are numerous and varied, but those of most common occurrence are nervous prostration and diseases of the spinal cord. Impaired nutrition, caused by weakened digestion, rapid growth, or any derangement if allowed to continue will end in impoverished nutrition of the spinal cord, impairing the voluntary application of the nerve force. As one arm is used more than the other, it requires more muscular contractions on the other side to balance the weight of this arm; the result will be greater pressure on the cartilages on that side, which would be counterbalanced by involuntary action of the other if the weakened condition of the nerve did not prevent it. Often we see well-developed scoliosis which reveals on investigation impaired action of the digestive organs, or exhaustion of the nerve force occasioned by the parents permitting the child to be in continual excitement—one objection against children's parties where great light and excitement prevail. By aiding digestion and assimilation, and calling attention to the danger consequent upon undue stimulation of the child's faculties, cure has often resulted without local treatment.

We now see that all deformities are congenital or acquired, and are the result of an error in nutrition or assimilation, whether the injury affects nerve, bone, or muscular tissue. Monstrosities and some other deformities are said to result from great nervous shock. This can only occur when there is impaired nutrition of the nerve tissue. Deep emotions and great mental agitation may impair digestion and thus injure the nutritive force and lead the way to imperfect development. I have no hesitancy in saying that parents in perfect health, whose nutrition and

assimilation, secretion and excretion, are normal, never are afflicted with children having congenital deformities. No child in perfect health acquires deformities. The disease, whether it is malnutrition or malassimilation, may be corrected by medicines, hygiene, and sanitary influences. Parents produce children having similar natures and tendencies to their own. Then by restoring health of the parent we prevent deformities of the child. Every deformity prevented gives an increasing benefit to the world over many cured. We have no decree that in this nation only the fittest shall survive, but there is a demand for great minds to design and execute laws for bettering the condition of human living. The perfect in mind may be expected where we find the perfect body. There is a growing interest in the methods of the few laboring for this desirable purpose. I have no discovery to announce, nor Utopian theory to present, but rather at this jubilee session refer to the accomplishments of the members of this American Institute of Homeopathy. The bureau of pedology was established in 1873 at the suggestion of Dr. I. T. Talbot. Since that time clinical experience and scientific researches in behalf of children have been yearly reported to this body. Characteristic of our school, the dietetic, hygienic, and prophylactic measures have been held of great importance and always advocated to precede and accompany remedial agencies.

A limited number—I know not how many—have for years practiced prenatal and prophylactic medication. The administration of constitutional remedies extending through pregnancy, infancy, and childhood has in many instances corrected errors of nutrition or assimilation, and contributed to the relief of suffering for the mother and more perfect development for the child at birth, and by continuing the remedies finally made latent unhealthful tendencies. I would not confine my illustrations to my own experience, but include the well-authenticated reports

of other members found in the literature of our school during the past year or so. The living and treatment have been outlined that will banish the rachitic condition. There are many evidences that potentized remedies have a deeper influence than any product of the chemists in dispersing the earliest indications of this dyscrasia.

It is well established that grief or unhappy mental states may impair digestion and thus divert nutrition, which later results in the deformity of non-development. Bryonia, china, chamomilla, or similar agents given early are able to cure the individual and thereby protect his descendants from imperfect form. Reports have clearly shown that parents not suffering pain, and considered in good health, had some error in digestion or circulation and their children had cleft palate or hare-lip. Later by a course of prenatal medication these deformities were absent, but on omitting treatment the next child was thus afflicted, showing a demand for continued effort. And by continued treatment this deformity may cease with the generation of its origin. Several cases are known where sulphur and calcaria were administered during pregnancy and resulted in improved health for the mother and perfect development for the child where previous ones had spina bifida or talipes.

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## HOW TO IMPROVE CHILDREN OF THE FUTURE.\*

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BY

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**T**O discover any new truth in medicine or any of its collaterals should be a source of great happiness to him or her who made that discovery. To be able to communicate it to mankind is a blessing to the whole world.

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Hahnemann was made happy and renowned by discovering the law of cure by *similes*. He was happy that his discovery was to make, as he believed, a new era in medicine, and to establish in the future a practice that would honor him in all countries of the world; and that he could treat diseases of children with a much less mortality than by the system of medicine he had been educated and instructed to follow.

The medicines that have been in use by the new school in the treatment of diseases peculiar to children since the days of Hahnemann are now being adopted by the *old school*, with the variation, in some cases, of a larger dose. Some doctors, I am sorry to say, who pretend to represent the new school, give doses that are more to be dreaded than the judicious practitioner of the old school in the treatment of children. I might quote from many authors and contributors to the medical journals to prove my position, but my own observation justifies me in making the foregoing statement.

Now respecting my subject, children: The physical condition and education of a child commences before it is born. The mother gives character, temperament, mental and physical development while it is in embryo. Psychology teaches that all we acquire is the result of sensation and perception—that through perception and action all education must begin. Her sanitary surroundings should be such as will best develop her mental as well as her physical body, thus helping to give her future offspring a better start in early life.

If more attention were paid to this fact there would be a lessening in the fearful mortality of children. Statistics show that a large percentum die before they reach the age of six months. The low state of vitality they inherit from their mothers does not prepare them to resist disease. We should impress upon mothers the necessity of giving to their little ones, if possible, a healthy body; for the mental

qualities of the child will depend largely upon its physical condition.

This, then, should be the first consideration: that the mother impart enough vitality to her child to stay the ravages of disease; it is of the highest importance to the future offspring—the mental and physical condition of the mother. She should try to stimulate into greater activity her own brain by reading the best literature, attending lectures, and doing everything that will give tone and development to her higher and better nature.

It is not always possible in the lower walks of life for the mother to devote as much time as has been suggested, but there are no conditions in which a woman can be placed that excuse her from doing something for her future offspring, because there are so many avenues open for the cultivation and improvement of all classes and conditions of society.

There is not a shadow of a doubt but that the surroundings of the mother at that time leave their impress upon the unborn babe. Such being the case, the husband should try, as much as is within his power, to make this period one of the brightest and happiest in home life, encouraging the love of all that is beautiful, and lessening as much as possible the cares and trials to which she is subjected in her family duties. Let a spirit of love and gentleness govern every action. Let her control all outbursts of passion—avoid despondency, grief, fear, hatred. In their place let there be cultivated the love of music, flowers, pictures, as it will influence her in overcoming all the lower and baser passions. This noble work must be entered into by both husband and wife, for upon their deeds and actions depend the future development and welfare of the unborn. The husband should, by every deed and act, help and encourage her to make all possible effort to insure the most perfect psychological and physical conditions of the expected offspring.



It is an undeniable fact that parents stamp their good or bad qualities upon their children. If the mother could hold in check everything in her character that is undesirable even the most dissolute might improve the conditions of their future children.

One of the first steps is to improve the condition of the infant—try to give it a healthy body, and a mind as free from the taint of inherited vice as possible. How we may best attain this end is now puzzling the optimist.

The most reasonable theory is to begin the work of reform on the mother. Let her influence for good be felt upon the character of the child—commencing to form thus early the foundation upon which to build later the mature character of the man or woman. I have said that the hope of future improvement of the race depends upon the mother; and I believe it to be true. If our reformers could be made to see this fact, with all its bearings upon society, the work of reformation will have taken a long stride in the right direction.

#### FEEDING OF INFANTS.

Nourishment for the babe becomes the great factor in this stage of existence. God intended that mother's milk should be the proper nourishment for her offspring, as proven by the lower classes of mammalia. It approaches nearest in its composition to the blood, and, like it, contains (after standing in an open bowl or dish) one solid, one fluid.

It is well known to every physician that it varies in quality in different mothers, according to the state of their health, temperament, and hygienic environments. Its chemical qualities also vary in different mothers; the milk of one who looks healthy does not nourish her infant. Mental as well as physical affections exert an influence upon the quality and quantity of the secretion. Inflammatory condition of the mammary glands is liable to affect

the milk. Menstruation during the nursing period changes the chemical composition, because whatever phosphate of lime exists in the milk is then eliminated. Pregnancy during the nursing period lessens the richness of the milk, and the child becomes emaciated from the lack of proper food. From the mother's milk the child may have spasms, colic, diarrhea, vomiting, diseases of the brain and osseous system.

During the past year I call to mind three mothers who had instrumental labor; one had chloroform for some hours; two were under the influence of ether. In each case the child would refuse the breast when offered. In both cases where ether had been administered they were nauseated when the attempt was made to have them nurse. This effect continued on the child for three or four days. The anæsthetic was undoubtedly taken up by the secretory organs and the milk became impregnated with it.

In the case of Mrs. B., who had chloroform for several hours, the child was affected with less nausea, but would not nurse freely until the fifth day. In each case the mother was healthy and her recovery unusually good.

To secure the proper food for infants, the medical profession and chemists have been experimenting for centuries. Nearest in chemical qualities to mothers' milk is goats' or mares' milk, but it is no easy task to supply ill-fed children with that quality of food. We must look for the kind that will be adapted to each individual infant. Cows' milk has less sugar, more protein, and more fat than mothers' milk. Mothers' milk is slightly alkaline; cows' milk has traces of acid in it which makes it liable to form casein in the infant's stomach.

From a sanitary point, when cow's milk is used the cow should be healthy, the stables where she is kept should have plenty of air space, well ventilated, well drained, and plenty of sunlight, plenty of pure water, well fed on clean, wholesome food. In the summer months sterilize the milk to destroy any germs that may exist.

Milk may be peptonized. If, after using milk, the children do not thrive, the various foods for infants that flood the country may be used successfully, such as Mellin's, Carnrick's, Nestles', and Imperial Granum. Condensed milk is often desirable to use where an infant has weak digestive powers. Barley water stands pre-eminent, as barley will digest sooner than any other food that I have mentioned.

Two or three years ago the American Medical Association appointed a committee to ascertain the best food for infants and make their report in 1893 to the association. Here is the result of their report :

The Committee of the American Medical Association referred to agreed that if pure milk from perfectly healthy cows were partially predigested by the process of peptonization with fresh pancreatine, the temperature sufficiently raised to destroy the ferments, then reduced to a powder by evaporation, and to this added dextrine to supply the carbohydrate, we would then come as near the production of a proper food for infants as might be possible in the absence of the healthy mother's milk, the latter always being given the preference.

Some objections were made to this report ; one recommending that lime be added, another that all milk should be tested in a chemical laboratory. The first suggestion was made by an anatomist of a medical college the second by a chemist in a medical college.

I have presented in brief the best method for feeding the child in early life. If a child be not properly nourished it could not be properly educated.

Soon after birth the psychological education commences ; it seems to comprehend the sense of touch and begins its education by sensation ; then follows perception. Both are acted out in early life. The mother and nurse are the first teachers in its education, therefore they should be loving, of even temper, and the nurse should possess good health and a certain amount of magnetism to soothe and quiet the child. Her voice soft, and her gentle music has its charms, as we all know how mothers sing and rock their loved ones

to sleep. It soon learns to handle—sense of feeling more acute—seeing objects—hearing—all now begin to enter into its education. As months go by the brain becomes more active, and the child begins to comprehend things said and done around it.

The infant is active from the impulse to prove by the sense of touch the impressions received by the eye and ear. The mother should give the child object lessons, thereby increasing its reason, its perception, its action. It will then comprehend things said and done that take place around it. This primary teaching may continue for three or four years, always inculcating in the child principles of right, unselfishness, truthfulness, honesty, and obedience—all of which will conform with the child's health and the teaching of its higher organization. This period of education in its early life devolves almost entirely upon the parents or nurse. This early education will prepare the child for entering upon the next state with comprehensive activity.

The kindergarten work now begins. The teacher should be mistress of her work; she should be able to impart to her pupils what she knows; she must devote all her energies with an intensity that enlists body and soul; she should be able to direct each pupil to his possibilities and requirements; she must establish a close affinity between herself and the little ones around her. She must love her pupils and be loved by them. She must have the power of concentration—the power to guide and direct. She must possess a psychological knowledge to educate the pupil in the channel that will promote its success in studies and future happiness.

It has been said that while there may not be much music in medicine there is a great deal of medicine in music. It will quiet and soothe the insane, allay fevers, often cures insomnia, aids digestion, increases vitality.

## THE USE AND ABUSE OF OBSTETRIC FORCEPS.

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THE forceps have not inappropriately been termed the great prime mover of obstetrics.

It is scarcely possible to exaggerate the importance of this instrument, which is simple in construction, easy of application, and marvelous in power; and besides, the greater frequency with which we avail ourselves of its aid as compared with other methods of instrumental and operative assistance fully entitles it and its application in practice to the prominent position in which the subject is invariably placed.

The ancients discovered and were in the habit of using an instrument which, in the principle of its construction, is identical with the modern forceps. The period at which the discovery was made is not definitely known, but we are quite certain they were used by the Arabian physicians as early as the eleventh century. This important discovery was, however, completely lost sight of in the gloom of the Dark Ages, nor was it until near the middle of the seventeenth century that it was rediscovered, and after a long interval of secrecy finally introduced into practice.

Previous to that time when there was delay in childbirth, and it was found that the labor could not be finished by the natural expulsive powers, the physician was compelled to use the blunt hook, which was inserted into the eye or some other part of the head of the child, and of course the result was death of the child in a great majority of cases, and was also a source of great danger to the mother. Should the child live through such an ordeal it was mutilated and disfigured for life. How repugnant this

must have been to the sympathetic physician, and what a feeling of horror would steal over him upon meeting one of these victims of the imperfection of the practice of obstetrics.

The teachings of the past have tended to educate physicians to look with dread upon and avoid the use of forceps. In looking over the older text-books we find them advocating the use of forceps only as a last resort. One author says "not to interfere until the second stage of labor has continued twenty-four hours without delivery having been accomplished"; and that we should not be too hasty even then in their application. Another says "they are to be applied in no case until we are perfectly satisfied that the obstacle cannot be overcome by the natural powers."

Can it be possible that there is in this audience a physician who would follow in his practice the rules above mentioned? No! I am persuaded to believe better things of you. I trust that no member of this intelligent and progressive association would let a parturient woman suffer the agonizing pains of labor twenty-four hours when you can safely and quickly deliver her with forceps in as many minutes.

The accoucheur who boastingly says he has been in practice many years and never saw the need of or used an implement to aid in delivery is apt to hold his obstetric ability in too high estimation. He does not consider that in the issue of chances running in his favor he is about to encounter a case he cannot deliver without instrumental aid. He may have been patient, skillful, and adroit, but he has also been lucky. He is near the end of a career that is to terminate in disaster.

How can an obstetrician be shallow enough to boast of his skill while permitting his confiding patient to suffer for naught, hour after hour, useless and ineffective agony, imposing upon her what she need not endure—imploing her to martyr herself when she might be delivered with forceps

safely and successfully in a few moments? The impudence or foolishness of such pretenders is hard to be believed; nevertheless I have had personal knowledge of just such practice more than once; but the fact is plain that the time approaches when the obstetric practice of conceited blunderers will become pinchingly restricted. Intelligent women are demanding the skill of operative obstetricians—of those who deliver with forceps as soon as labor is becoming needlessly prolonged.

The accoucheur may encourage the lying-in woman to keep up her courage and persevere; he may assure her that she is "enduring only what the Almighty in his infinite wisdom has imposed upon womankind for the perpetuation of the race," and receive an encouraging response; yet human nature has its limits of endurance—it will at length succumb to prolonged and exhausting efforts. An unwarranted risk is being incurred through the obstinacy and bigotry of an overconfident obstetrician or midwife. The woman is dying of exhaustion, yet the stupid medical attendant is ambitious to say that he (or she) has never had occasion to call into use instrumental aid. What a silly piece of egotism! what a professional error! what despicable malpractice, whether discovered or not! Has a medical man no conscience when he must know that he is holding an innocent and ignorant victim over the brink of the grave, while it is in human power to save?

The abuse of forceps is in my opinion quite infrequent. I have in mind, however, a case that might be called an abuse of them, or at least the operator did not exhibit that degree of skill I had given him the credit of possessing. Not long since I was called to aid two physicians in an obstetrical case in which one of them had been engaged all day and night, and had made repeated but unavailing efforts to deliver with forceps without success.

The second was called, but did not believe it necessary to use forceps under any circumstances, having, as he said,

been in practice thirty years without using them. Here were the two extremes; the first was right in using forceps without delay, but, unfortunately, was not skillful in their use, having, as I was afterward informed, used all the force possible, finally standing with his feet upon the edge of the bed, lifting and pulling with all his strength, exhausting himself and producing a complete rupture of the perineum in his unskillful and unsuccessful efforts.

Such were the conditions on my arrival. Dismay and discouragement prevailed. The woman was rapidly losing strength and hope; her mother and husband were discouraged. The attending physician, as he admitted to me, was worn out and unable to continue longer. The consulting physician angrily paced up and down the room, advising them to let nature take its course, and denouncing meddlesome midwifery in no uncertain tones.

On examination I found an extended and impacted head, immovably wedged in the inferior strait, evidently having been in that position many hours. Applying my forceps, slightly flexing the head, and with a few gentle words of encouragement during the next two or three pains, had the delivery completed, so quietly and easily that all were surprised. Bidding the family and my medical friends a courteous good-morning, I retired. I was somewhat surprised, as well as complimented, a few days later when I heard in an indirect way that the attending physician had expressed himself in this manner: "What a pity Dr. W. is not of our school so that we consult with him."

Instruments are not necessary in normal labor, but are of the greatest aid to the accoucheur when uterine inertia, lodgment, and other damaging delays retard delivery. If from any cause in the second stage labor is retarded any considerable time, I employ the forceps. They are life-saving and not death-dealing implements. For obvious reasons obstetrical forceps are not in good repute with a practitioner of medicine who knows little or nothing of their marvelous power.



On the other hand, the most enthusiastic champions of the implements are among those who have used them most, and best understand their transcendent capacities as aids in obstructed labor. The obstetrician who has employed forceps on repeated occasions becomes an ardent admirer of this pain-lessening and time-saving invention.

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## RUPTURE OF THE UTERUS COMPLICATING PARTURITION.

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BY

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WHILE uterine rupture, or laceration of the uterine body, is confessedly one of the gravest accidents that can occur to the woman in labor, it is so infrequent in occurrence, or so seldom recognized, or medical men are so reluctant to speak of it, that the writer has yet to see the first article regarding it in a medical journal, or to hear the subject discussed in a medical society; and it is with the hope of bringing about such discussion that this article is presented.

Most of the recorded cases have come from hospital practice, with a small addition from the private practice of eminent specialists; and, as only a small fraction of obstetrical cases come under the notice of hospital attendants and specialists, evidently many, perhaps hundreds of cases, occur which never go beyond the ken of the solitary, busy man, humbly doing his best to save his patient's life; and who, lacking the light thrown upon obscure cases by autopsies, wonders why, in spite of his best efforts, his patient died of hemorrhage or septicæmia.

Among predisposing causes are: a narrowing of the

bony pelvis sufficiently to preclude the possibility of the passage of the fetus; thinning of the uterine muscle in some portion by previous disease or operation; hydrocephalus or ascites of the fetus; shoulder or trunk presentation furnishing a solid obstacle to the efforts of the uterus to expel its contents; in short, any condition of the maternal or fetal parts that renders unavailing the expulsive efforts of the uterus.

As exciting causes may be considered: administration of ergot in the first stage of labor; neglect or inability of the attendant to correct the malpresentation or reduce the abnormal size of the fetus sufficiently to allow of its passage, or to increase the size of the bony outlet by symphyseotomy; introducing the hand for purpose of version into an already overdistended lower portion of the uterus, especially during a contraction; podalic version in a closely and firmly retracted uterus, and forcible traction in the attempt to deliver through an undilated and undilatable os.

It seems to me incredible that anyone should make so unskillful use of the obstetrical forceps or cephalotribe as to puncture the uterine walls, nor is any instance cited of such an occurrence by any of the authors who class such a seeming impossibility among the exciting causes.

One would expect that so formidable an accident would be accompanied by unmistakable diagnostic symptoms, but such is far from the fact; in truth, the greater number of cases remain undiagnosed until the autopsy reveals to the astonished physician the true cause of death. In a typical case the obstruction to the progress of labor, despite the powerful contractions, accompanied by anxiety and restlessness in the patient, then, during a strong contraction, the sudden outcry, the recession of the presenting part, the passing of a part or the whole of the fetus into the peritoneal cavity, and the entire cessation of contractions,

accompanied or immediately followed by deathly pallor, nausea and vomiting, sinking strength, cold perspiration and rapidly failing pulse, with anguish and collapse written on every feature, leaves no room for doubt as to the cause, and presents a picture sufficiently appalling to strike terror to the heart of the attendant and burn the memory of it into his very soul.

But typical cases are the exception and not the rule, though there will usually be the premonitory signs, the outcry during a pain, with a sensation as if something had given way, with hemorrhage more or less profuse, either external or, in case the fetus is wedged in the bony pelvis, into the abdominal cavity, with more or less of the signs of shock and collapse.

Of course each case will have to be treated on its individual merits, but there are some general principles that it will be safe to follow. First and most important is prophylaxis. He who is wise and discerning and familiar with the premonitory symptoms will avert the disaster by promptly emptying the uterus of its contents, employing craniotomy, embryotomy, version, symphyseotomy, Cæsarean section, whichever in his judgment best fills the indications. Version, however, is seldom indicated, as the introduction of the hand for that purpose, or the act of version itself, might precipitate what we are most anxious to avoid. Likewise symphyseotomy and Cæsarean section will seldom be of avail, both on account of the length of time consumed in preparation and execution, and from the gravity of the operations and the skill required to make them successful in saving both mother and child; and of course neither operation would be thought of if a hydrocephalic or dropsical fetus obstructed labor, or if the fetus were already dead. So, saving under exceptional conditions, the reduction of the presenting part and instant delivery of the fetus is all that is required in the way of preventive treatment. Likewise, after the accident has

occurred, the first consideration is the removal of the fetus by the same means that have been recommended in preventive treatment, with the important difference that no attempt need be made not to sacrifice the child, for it is agreed that it dies at once following the laceration, if it were not already dead. Since the only safety to the mother lies in emptying the uterus, no time should be lost in delivering by the readiest means consistent with preserving the integrity of the maternal tissues. In case laparotomy is performed, if the uterus contracts firmly it may be left in place, with or without the introduction of sutures to insure the wound remaining closed. Lacking contractions, it may, perhaps should, be removed with its appendages. The rate of mortality is frightful, about ninety-five per cent. dying in spite of treatment where rupture has occurred.

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## USE AND ABUSE OF PESSARIES.

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BY

ABBIE H. HINKLE, M. D.,

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**P**HYSIOLOGICAL displacements of the uterus are temporary or transient, passing when the causes (such as dilatation of the bladder, overdistention of the rectum, abdominal pressure, etc.) cease to operate. Pathological displacements are persistent, changing the position, form, and structure of the uterus. These have made the pessary a necessity in gynecological practice. The keeping of the uterus in place by a carefully adapted, properly adjusted pessary is of the greatest importance. Dr. Ludlam, in his valuable work on "Diseases of Women," aptly defines a

pessary as a crutch or a prop that is used under protest, for the most part temporarily.

The Albert Smith, Hodge, or ring pessary is useful in fixing the cervix and supporting the uterus as a whole.

The mechanical action of pessaries should be understood in order to employ them with satisfactory results. Pernicious effects are produced from ignorance of the principles of their action or the methods of adaptation. A common, erroneous idea is that a certain form of pessary, or certain kinds bearing the names of their inventors, should be used in all cases of displacement, slight variations in size being all that is required. A pessary—the particular form and size required—should be shaped to each case, and placed in position after restoring the uterus. A pessary that can be modeled to any form is made of whalebone and fine copper wire, and then covered with soft rubber. Where inflammation or ulceration exists the medicated tampon properly adjusted (which will both support and heal) is the most beneficial temporary support to the uterus. The tampon should be inserted daily or every second day; upon removing, a hot vaginal douche, medicated with calendula, hydrastis, or listerine, should be employed, and a freshly medicated tampon applied. The most comfortable and satisfactory tampon is made of antiseptic wool covered with a thin layer of absorbent cotton.

Pessaries are harmful in all kinds of uterine or circumuterine inflammation, in vaginitis, and in cases of subinvolution of the uterus. Great benefit is derived from their use in displacements in the early months of pregnancy, and in numerous other displacements with vaginal relaxation and prolapse, retroversions, procidentia, etc. Care must be taken that the pessary is not so large as to make general pressure on the walls of the vagina, nor of a shape that will make undue pressure on any particular point. In some cases the pessary must be several times changed in shape during the first few weeks, which is easily accomplished with the

materials above described. When the uterus is well in position, and the vagina in a normal, healthy condition, a hard rubber pessary can be made, using the soft one as a model. The pessary is recognized as the most valuable instrument in keeping the uterus in the position in which it is placed by the different repositings; its support favors the tendency toward the normal position. Where there has been a laceration of the cervix uteri it should be repaired; if the perineum has been injured it should also be operated upon; the pelvic floor and uterus should be in as nearly normal condition as possible in order to cure retroversion, prolapse, and procidentia.

From an article by Dr. Frank P. Foster of New York on the mechanical action of pessaries I quote the three ways in which vaginal pessaries most commonly effect changes in the uterus: "(1) A pessary may operate by virtue of mere lateral distention of the vagina, being itself too bulky to escape readily from the pelvic outlet, and thus preventing the parts resting upon it from so escaping; (2) that the pressure exerted by a pessary may be transmitted directly to the body of the uterus, lifting it up when anteverted or retroverted, as the case may be; and (3) that such pressure may operate by dragging the lower portion of the organ in a certain direction, thus causing its upper portion to move in the opposite direction.

"In regard to the method of action *first* mentioned—that of lateral or transverse distention of the vagina—it may simply be said to apply only to special forms of pessaries, which, although in common use before Hodge's time, have now almost fallen into disuse—deservedly, I may be allowed to add.

"The *second* method—that of pressure transmitted directly to the body of the uterus—is undoubtedly the one most prominent in men's minds, most taken into account in practice, and most appealed to in teaching, and yet, it seems to me, its scope is really quite limited and its prac-

tical importance almost nil. If an extreme malposture of the uterus is corrected by the act of inserting a pessary adapted to the case, as may often enough be done, the instrument may act at first, I admit, by direct transmission of its pressure to the body of the organ, lifting the latter from a state of extreme anteversion or retroversion, as the case may be; but such action is only momentary; long before it could restore the uterus to its normal attitude another agency is called into play, so that when the full action of the pessary is attained its presence is no longer transmitted to the body of the organ. In any case, then, this direct action on the body of the uterus is of but momentary duration, and accomplishes but a partial result; and if the malposture is not originally very decided, or if it is corrected before the instrument is inserted into the vagina, it does not come into play at all.

"These statements embody no novelty, but they are so at variance with the views held by the most influential teachers of gynecology that it seems best to put forward some reasons for them. To illustrate, then, suppose a case of retroversion. In order that a pessary may fully restore the uterus to its normal attitude, and hold it in such attitude (acting all the time by direct pressure on the body of the organ,) its pressure must be exerted not only upward, but forward, and that too at a point situated high in the pelvis. Now, from my own experience, from observation of the practice of others, and from the drawings employed by authors to illustrate the action of pessaries, I believe that pessaries long enough to fulfill these conditions are seldom, if ever, used. Granting, however, that I may be mistaken in this respect, it will scarcely be disputed that either such a pessary, besides being very long, must have a very pronounced curve in order to enable its middle portion to lie wholly below the face of the cervix, while its upper end exerts the pressure in question (in which case its introduction, supposing the perineum to be intact, would be

well-nigh impossible), or else its limbs must diverge to such an extent as to accommodate the cervix between them, making the instrument very broad, in which case it would not pass between the two utero-sacral ligaments without stretching them apart to such a degree as practically to shorten them, thus causing them to pull the lower portion of the uterus backward, and consequently throw its upper portion forward. The result of this latter state of things would be that the retroversion would be corrected before the upper end of the instrument had been forced high enough to restore the body of the uterus to its normal position by direct pressure upon it, or by pressure directly transmitted to it. Further than this, I believe that in the great majority of instances the mere upward and backward pressure upon the posterior vault of the vagina would suffice to drag the cervix backward in the same way before the instrument had penetrated at all into the space included between the utero-sacral ligaments. This, however, would depend upon the degree of tonicity with which the vagina was endowed.

“With regard to anteversion the case is even stronger, while at the same time it is simpler, for the anterior wall of the vagina is naturally tense, and its tension is usually heightened by the mere fact of the uterus being in a state of anteversion. In this tense condition of the anterior vaginal wall we have a marked contrast to the posterior wall; the latter is much longer than a straight line drawn between its two extremities, and its lower end is connected with parts that are comparatively mobile; the former is firmly attached to the pubic arch. By reason of this tension of the anterior wall of the vagina its virtual shortening occurs almost at once whenever any noteworthy pressure is made upon it; hence, any of the various forms of anteversion pessaries that are supposed to act by lifting the body of the uterus directly up really accomplish its ascent by stretching the anterior wall of the vagina, and thus dragging the cervix



forward. In proof of this statement witness the insignificant size of the anterior projections of these instruments—projections utterly incapable of reaching to the height that they would have to reach in order to make direct pressure upon the body of the uterus, even with the bladder intervening, when the organ had approached anywhere near its normal position. The great sensitiveness of the anterior vaginal wall to pressure, the well-known liability of ulceration to occur upon it under the pressure of a pessary, both point to its greater tension as compared with the posterior wall.

“Passing now to the third of the various methods of action that I have attributed to pessaries—that of traction upon the lower portion of the uterus—but little need be said about it, for the consideration brought forward to show the limited scope of the direct pressure theory, all conspire to advance the traction theory to the most important position. Such, I believe, it ought to occupy, unless the statements I have put forth are shown to be erroneous, I will simply add that always in anteversion, and usually in retroversion, it is through the medium of the vaginal wall, in my opinion, that pessaries make traction upon the cervix.

“I will briefly mention some of the practical applications of the doctrine I have sought to uphold. In cases of retroversion it is usually sufficient, if pessaries are to be used at all, to employ an instrument simply with the idea of making backward pressure upon the posterior wall of the vagina, directing the pressure somewhat upward, unless there are special reasons for not doing so, but not resorting to pessaries with such an exaggerated pelvic curve as to render their introduction difficult. If the instrument is curved rather sharply at a point very near the upper end, the pressure will be distributed more evenly over the posterior vault of the vagina, and, therefore, will be borne better.

“The usual forms of retroversion pessaries (the Hodge

instrument and its various modifications, including those with external support) seem to me to act in this way, and to be as unobjectionable as any we are likely to hit upon. More or less stretching of the posterior vault of the vagina is apt to result, but it is of little consequence, even should it prove permanent, for it in no wise interferes with the natural functions of the parts. Broad pessaries, penetrating between the utero-sacral ligaments, should never be used, for these ligaments form a part of the mechanism by which the normal situation and attitude of the uterus are maintained, and anything that stretches and relaxes them interferes with the permanent cure of retroversion."

The vaginal walls are injured from overdilatation by pessaries that are too large. In such cases the pessaries should be removed, and rest and astringent injections prescribed for restoration of the injured parts. Vaginitis, vulvitis, inflammation of the bladder, urethra, uterus, pelvic cellular tissue, and peritoneum, also ulceration and fistulæ, have been caused from badly adjusted or unsuitable pessaries, or from pessaries that have been worn too long.

Acute inflammation of the uterus and surrounding tissues—cellulitis and peritonitis—have frequently been caused by stem pessaries; all stem pessaries having attached a band around the body prove injurious when worn for any length of time. Many cases of embedded pessaries are described in our medical works. No doubt some of us have seen one or more such in our practice.

Authorities differ as to the use of pessaries, but the important fact remains that they have proved of great value in varied forms of uterine displacements, giving prompt and efficient relief to the patient which could not have been obtained otherwise. It should therefore be our aim to acquire the best knowledge of selecting, making, and using them skillfully, so as to obtain the most gratifying results and avoid the mischief and injuries which have been

described as following their misuse and ignorance as to their application and mechanical action.

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A CASE OF RUPTURED TUBAL PREGNANCY.  
OPERATION. RECOVERY.

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BY

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THE following case occurred in the practice of Dr. Calderwood, who asked me to see the patient with him a few months ago. She had been married but a short time, and the menstrual period due a fortnight previously had not appeared. She had been in fairly good health, suffering but little in any way. Three days previously she had had some pain in the pelvic region, which was considered due to an irregularity of the bowels. She was given medicine for this with instructions to report without delay if she did not improve. The next day she was better, the following night she had more pain, and suddenly fainted in bed early the next morning. Dr. Calderwood was then called again. He found her in collapse, with white, pinched face, cold sweat on forehead, almost pulseless at the wrist, and in a half-conscious condition. He promptly diagnosed ruptured extra-uterine pregnancy and immediately asked me to see his case.

I found the abdomen distended and tense, with more sensitiveness in the right than in the left ovarian region. Bi-manual examination revealed nothing more than an unusual fullness or tenseness in the pelvic region. It will be remembered that free blood in the peritoneal cavity cannot be outlined as a mass. The patient had reacted a little,

was conscious and vomiting greenish fluid and some mucus. The pulse was very fine and rapid, the surface of the body and the extremities were cold. Further examination was not made, as there was some danger of extending the rupture and increasing the hemorrhage and there was ample evidence to support Dr. Calderwood's diagnosis.

The place where she lived was unfit for an abdominal operation as it was, and there was no time to waste in preparations. I had her wrapped in blankets and removed at once to the Massachusetts Homeopathic Hospital, where her abdomen was hastily cleansed, her clothing changed, and she was placed on the operating table. This was done as rapidly as circumstances would permit, as she was gradually sinking. I opened the abdominal wall without stopping to compress bleeding vessels. With the first incision of the peritoneum the blood and clots almost spirted as they gushed out of the peritoneal cavity. No heed was given to this and the fingers were introduced into the right side of the pelvis; as that side had been the more painful, it was supposed to contain the tubal pregnancy. The tube was not enlarged and the left tube was found to contain the product of conception. It was immediately ligatured and this arrested all hemorrhage. The abdomen then was cleansed as carefully as the condition of the patient would permit, repeated flushing of the abdomen with hot water and hypodermics of brandy being necessary to stimulate the patient. The right tube was bound down with some adhesions and it was thought best to remove it with the ovary to guard against repetition of her condition. A quantity of hot water was left in the peritoneal cavity for absorption, thus furnishing a circulating medium, a drainage tube was inserted and the abdomen closed in the usual manner; after which, a quart of normal salt solution was injected at intervals into the rectum.

The patient was put to bed with plenty of hot water bottles and, besides the usual treatment after laparotomy,

she received brandy, strychnia, and later tincture of china. She made an excellent recovery in spite of the extreme anæmia and slight sub-normal temperature during the first few days. I wish to express my thanks to Dr. W. J. Winn for his courtesy in kindly assisting and advising with me during the operation. Dr. Calderwood deserves much praise for his accurate diagnosis and prompt decision. The patient owes her life to him for it.

The diagnosis of extra-uterine pregnancy in the early months previous to rupture is difficult and very rarely accomplished, as the patient is unaware of her danger till rupture of the gestation sac takes place. Lawson Tait, who has had more experience with ectopic gestation than any other man, is of the opinion that extra-uterine pregnancy is never diagnosed till after rupture. If the rupture is slight and large blood vessels are not involved the symptoms are not severe and their cause is easily overlooked. If the ovum continues to develop, an extension of the laceration and dangerous symptoms appear. If the laceration of the tube opens into the broad ligament, a hemothorax is formed, the escape of blood is arrested by the opposing force of the tissues and the coagulations of the blood. The ovum dies and the patient recovers.

If the laceration in the tube opens into the peritoneal cavity, the blood finds an easy outlet with no opposing force, and unless the bleeding is arrested the patient dies from internal hemorrhage.

These facts are interesting in relation to the claims of electrical treatment. In the first place, diagnosis of extra-uterine pregnancy previous to rupture in the early months is so difficult that it is open to question by those of the largest experience. Secondly, if rupture has taken place into the broad ligament, very little treatment except rest is needed. The ovum almost invariably dies and the patient recovers whether she is given sac. lac. or electricity. Finally, when we find a patient suffering from hemorrhage, our

duty is to arrest it as soon as possible ; in other words, we must promptly ligate the vessels of a ruptured tubal pregnancy for the same reason that we would ligate a divided radial artery ; to delay such treatment by remedies, by stimulants, or by electricity is to gamble with human life while the enemy holds the trump cards.

The great distinctive feature of ruptured tubal pregnancy is internal hemorrhage with the well-known symptoms of collapse, which may be followed by apparent improvement, and then by repeated collapse or peritonitis. The collapse may come without warning and death ensue within a few hours, but usually there are symptoms due to slight ruptures which occur from three days to a week before the more serious symptoms appear. The first and most important symptoms is sudden, sharp, colicky pain in one of the ovarian regions without apparent reason about ten days or a fortnight after skipping a period. This symptom is of more importance if it happens in a woman who has not for a long time conceived. Rupture of the tube takes place about the sixth week of pregnancy in the very great majority of cases, though in very rare exceptions there is reason to believe final rupture has been delayed for ten weeks. This pain is caused by the separation of the muscular fibers and often is followed by a slight discharge of blood from the uterus and more or less of the decidua vera, but both of these last symptoms are subordinate to the first one. A careful bi-manual examination may disclose nothing in fleshy women, as the distended tube is comparatively small ; but if slight enlargement is detected, the danger of properly making an exploratory abdominal incision is far less than the danger of waiting for further rupture and collapse, with far more unfavorable conditions for recovery. If a large mass like an exudation can be felt, particularly if it apparently encircles the rectum, there is reason to believe a hematocele has formed and that in time the patient will recover without an operation.

The removal of the remaining tube and ovary occupies debatable ground, and should be governed by their physical conditions. If they appear perfectly healthy and free from adhesions it is more prudent to leave them, but unless both these conditions are present the ultimate welfare of the patient requires their removal. There is evidence constantly accumulating which appears to show that the same causes producing extra-uterine pregnancy in one side of the pelvis may produce it in the other. I know of one case in which a tubal pregnancy was found in both fallopian tubes, and at the time I operated on the above case a woman in the hospital had had the same operation performed a second time.

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## ABORTION FROM A MALFORMED UTERUS.

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BY

ANNA M. PARKER, M. D.,

CHICAGO.

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**F**EBRUARY 22 was called to attend Mrs. A., a Swedish woman aged twenty-seven, three years married, miscarried at six weeks two years after.

Found her suffering with uterine hemorrhage which aconite promptly relieved.

March 23 the hemorrhage returned, and was again checked by aconite. Pregnancy was suspected, and the patient was told to assume the recumbent position three days previous to the next menstrual period. Accordingly on April 17, the patient went to bed and remained one week. While in bed she had considerable pain, but was relieved by a hot douche, and no flow appeared. She was allowed to sit up and go about the house, but was careful

not to overexert herself. April 29, hemorrhage began again and aconite, caulophyllum, and pulsatilla each seemed to be indicated, and each relieved for a time, yet, on May 3, the patient having become almost exsanguineous, secale was given and promptly checked the flow. She now had an interval of rest, but on the evening of May 5, severe pains, beginning in the back and coming forward to the abdomen, then shooting upward and down the backs of the legs, with great restlessness and some irritability, came on. Chamomilla was exhibited and promptly relieved. The remedy was discontinued. In the night of the 7th was called again, condition similar, again chamomilla relieved. The patient was told that gestation was not likely to be completed. To which she replied that she was very anxious to complete it, but that the physician who attended her before had said that it would be impossible for her to carry a child to term. Still that she was very anxious to do so, and that if it was a question of saving pain to her, she felt able to bear a great deal and preferred to try further. Bell. seemed indicated, no less by the headache than by the fact that the os uteri was firmly closed. This gave another interval of rest. On the 9th the pains recurred, and she was then assured that the termination of pregnancy in abortion was to be expected and desired.

By remedies such as gelsemium and secale, and by hip baths, douches, etc., the patient was carried along in the hope of delivery without special interference, but on the evening of May 11, although the patient was having hard contractions of the uterus, the os remained closed, hard, and unyielding. Hot lard was applied to the cervix, and cal. carb. and all remedies which seem indicated having failed to produce relaxation, the patient was given amyl. nit. to inhale, with no result. Feeling that now other measures must be taken, the patient was anæsthetized and Paisley's dilator introduced into the cervical canal, and with great patience and considerable force, it was dilated to a



sufficient degree to admit the tip of the index finger, an attempt to pass the sound or other instrument upon the finger into and through the internal os being unsuccessful, and bringing on uterine contraction, when the finger was grasped—contraction being so great as to make the finger numb.

Having now reached the end of my physical endurance, and being convinced that the os was undilatable, I decided that incision was necessary. For that purpose I called the late Dr. Walter F. Knoll, on the afternoon of May 12.

Dr. Knoll advised the use of the bivalve speculum and forceps as better and quicker than incision. A rectal speculum was accordingly forced into the cervix, the fetal head seized with bone forceps and forcibly delivered.

The difficulty in delivery being that with every uterine contraction the cervix was elongated and firmly closed, and the fetus pushed up into the fundus and firmly held. While Dr. Knoll was delivering her he made the remark: "I am using all the strength of which I am master." It being inquired if inversion was to be feared, the reply was: "Not more than if this was steel." Sufficient force to drag the patient from her bed, had she not been held, and to raise the surgeon from his chair was required to overcome the uterine grasp.

The placenta was forcibly delivered and the hand of the surgeon bore the mark of the uterine contraction when withdrawn. The texture of the organ was likened to bone.

The placenta had become fibroid either as a result of hemorrhage, or pressure, or both, and the fetus was malformed—being without a lower jaw or chin, and the head a hard cartilaginous cup.

The cervix was, of course, badly lacerated, but despite the loss of blood, the many attempts to dilatation, and the many and extreme contractions of the organs, the patient made a rapid recovery, had no signs of metritis, or fever, and was kept in bed two weeks with difficulty. At the end

of that time she had recovered her strength and was apparently well and she has remained in good health since.

The patient gave a history of very hard work, carrying loads, drawing cord wood on a sled in a harness, and other heavy work, so that at seventeen she was no larger than a child of ten years should be.

The womb had undoubtedly reached its greatest degree of expansion. The fetus was about at the fourth month, and whether the lack of further expansibility was due to arrest of developement or to the malformation remains a question.

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## PROHPYLACTICS IN DISEASE IN CHILDREN.

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BY

F. S. NICHOLS, M. D.,

PLANO, ILL.

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THE subject of the prophylactic action of remedies furnishes a fruitful field of study. Since the advent of the germ theory of diseases, nearly every known germicide has been recommended not only as a cure but as a preventive of disease. I do not propose, however, to discuss this phase of the subject of prophylactics. Indeed, it would be worse than useless to recount the failures of this haphazard method of medication.

It was Hahnemann who sounded the keynote of true prophylaxis, and to-day, even among the rankest allopaths, we find belladonna given in minute doses as a preventive of scarlatina. A magnificent tribute, although unwillingly rendered, to the illustrious founder of homeopathy.

The particular aspect of the subject which I propose to call your attention to is where an impoverished condition of the system renders it more susceptible to any disease

which may chance to attack it. This condition is more frequently observed in children whose food has not been perfectly adapted to the individual.

Too little attention has been given to the feeding of children during their second and third years. If a condition of diarrhea exists, the parents are solicitous for the child's welfare. But if the opposite condition obtains they are usually satisfied that the digestion is not at fault, and even many physicians will pass constipation in children without giving it a second thought, assuring the parents that it will correct itself in time; or empirically prescribe castoria, calcaria, etc.

If we are to prevent diseases in children we must recognize the errors of digestion early and correct them.

How frequently do we see the condition to which I refer, the extreme picture of which is a pale, emaciated, or rarely a fleshy, child with large head and small neck, glaring eyes, projecting abdomen, and bony legs! Every movement of the child is languid, as though to invite an attack of disease.

In a lesser degree we see them every day. As we visit from house to house we see children whom we recognize at a glance as being poorly nourished. A pneumonia, dysentery, whooping cough, or any other disease lays hold of this class of children with great effect. I will record a few cases of this kind which are not unique, but are familiar to every general practitioner, the object being not to present anything new, but to emphasize the fact that this class of cases ought by all means to be recognized early and relief given.

The first case which I will sight is that of a child three years old. The only complaint was weakness and the passing of undigested food. It was a typical case, and the symptoms led me to prescribe calcaria phosphorica, which gave prompt relief and the child passed through the hot summer weather without the usual attacks of so-called summer complaints.

Case number two was child eight months old. The same condition had obtained in this child until it was reduced to a mere skeleton. Cholera infantum had set in and reduced the child to a point where its life was despaired of by three old-school physicians. Arsenicum controlled the acute symptoms, and calcaria phos. has carried the child along to a more vigorous healthy state.

The third case was one to which I was called in consultation with a nominal homeopathic physician. The child had whooping cough and was not expected to live twenty-four hours. This child had received nearly the whole materia medica in sections. This same condition to which I have referred was present, and I suggested calcaria phos., which was given. The whooping cough was not influenced especially, but the child regained its strength and fully recovered.

Case number four, a little girl three years old, of light complexion, very thin, was brought to me with the following history: Had been constipated from early infancy; had passed food undigested; was restless and nervous, and for the last year had had periodic attacks, at which time she became extremely nervous, with some fever. At one time had a convulsion of considerable severity. The physician who attended the case warned the parents of approaching tubercular meningitis.

The period of dentition is always a hard strain upon the constitution, and no child should be neglected at this time, but with some, constitutional treatment awakens a more active circulation, a stronger nerve, and builds up a firmer osseous structure, which will enable the individuals more readily to resist disease.

The remedies which I have found to do this most effectively are, silesia, calcaria carb., calcaria phos., sepia, and sulphur. These, used according to their indications, in connection with other means of securing good nourishment,

such as hygienic surroundings, will go far toward preventing the diseases so common in children.

With the profession sufficiently aroused upon this point, a large amount of the disease attendant upon early childhood could be avoided.

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### FROM WHAT DO THE MOST FREQUENT COMPLICATIONS OF OBSTETRICS AND GYNECOLOGY ARISE?

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BY

NANCY B. SHERMAN, M. D.,

KALAMAZOO, MICH.

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ANY person who has intelligently practiced obstetrics and gynecology, must have had the conviction forced upon him, that there is either a great preponderance of amateur obstetricians or obstetricians to whom experience must ever mean simply times without number. Taking the objective symptoms, with the history of gynecological patients into account, and excluding such results as arise from faulty environment, or from the ignorance or remissness of the patient, I believe that of all lesions arising from obstetrical causes, relaxed and torn perineums are the most frequent, and that this excess is the result of the unnecessary use and management of forceps. I am sure that in many localities the use of forceps, like operations for appendicitis, has become a fad, for which the doctor is not altogether responsible.

Many women whose attention is self-centered are averse to being surpassed even in physical distress, if it can be demonstrated by unusual or expensive appliances, and so the glamour of instrumental palliation attracts more than it frightens. Like a footman in livery, it seems to lend dis-

tion, and exclusiveness is more catching than measles, so chloroform and forceps become the qualifications which guide in the selection of an accoucheur. But this does not accord with our best standard for a physician, and scarcely exonerates him from establishing false methods. It is not a gracious thing to say that which implies such general censure, nor does it make it more gracious because it covers a field which we hope is less than proportionally homeopathic.

With such remedies as *caulophyllum*, *pulsatilla*, *gelsemium*, *belladonna*, *chamomilla* and a dozen others to command, it certainly should be less, though the temptation be great, and drug differentiation uncalled for, by turning to the obstetric bag for the remedy which the agonized clamor of the patient seems to indicate.

The patient is most interested in the result, be it for weal or for woe, early or remote ; but to the schools, to the profession, factors which produce unfavorable results ought to be of vital interest at all times.

If they are unfavorable because of imperfect anatomical training, or of a vague conception of pelvic planes and curves, and ten or twenty final examination questions do not determine a lack so important, the remedy ought to suggest itself to instructors. Judging from the gynecological harvest, the application of forceps seems to have been the one thing generally mastered : afterward strength and haste have been the factors of waste. The straight pull and the long pull have done the work, while the delicate pelvic organs and fascia have been merely the *pièce-de-resistance*.

I am sure a more praiseworthy skill is shown in the deliberate effort, which, except in cases of extreme inertia or placenta prævia, makes traction only during a pain ; which duly regards the pelvic curve, which does not forget that in the pelvic or most frequent mode of application ; the head is held over the occipito frontal or oblique diameter, and if rotation takes place, the blades must be carried into such

a position as will alone, by their added and unyielding bulk, endanger the perineum, if not removed before the head leaves the vulva.

A ripper understanding never forgets that the parturient act is physiological, and like other physiological forces may sometimes be aided, but rarely aborted or superseded, and this underlies the rarer, more humane skill, especially effective when supplemented by an intuitive sense, which promptly recognizes the first jarring note of inco-ordinating nerve forces, and by remedies, prudent suggestion, a keen, tireless, non-apprehensive interest without hint of preoccupation, which reassures the patient and allows all possible rest, a patiently abiding time, liberally using perineal emollients, quickly adopting a favoring chance of posture, in short, by an all-comprehensive vigilance and tact, controlling the conditions, the patient, and the result. Even impaction and malpositions are often overcome without the use of the forceps, saving the patient the untold evil reflexes of inhibited effort, which one day will be recognized as a frequent cause of tardy involution.

From elicited history in cases of so-called relaxed perineum, resulting from submucous tears or solution of continuity of muscular fibers, of partial or complete disruption of levator ani on one or both sides, the causes have seemed to be about equally divided between severe and prolonged pressure from the fetal head (for which a premature rupture of the membranes seemed oftenest responsible), and the sudden expulsion of the head, or its sudden dragging by the forceps, which amounts to the same thing, before a gradual stretching of the outlet had obtained.

Forceps, no doubt, facilitate delivery when progress is arrested by malposition of head at brim or in pelvis; forceps, no doubt, stimulate and supply uterine action, although homeopathic remedies seldom fail to preclude this necessity. Forceps have saved the mother many times from the evil consequences of a labor too prolonged, but

to anticipate such a need unduly has subjected many more to a lifelong martyrdom.

It would make an invaluable record, did the law require the registration of births by instrumental deliveries. In this presence it may seem invidious to recommend or refer to old methods so commonly accepted theoretically; but my observation has led me to conclude that theory is frequently ignored in practice, that the use of the designedly beneficent obstetrical forceps is too generally abused. If there be any foundation in fact for my belief, it is a matter to be deprecated.

If the conditions are in a degree local, as I have intimated, an expression of authoritative opinion might be correct. I am well aware that a wide difference of opinion as well as practice exists, and it is but fair to presume that every physician unquestionably designs to do the beneficent thing, which, fortunately or unfortunately, must ever remain a matter of individual judgment.

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## DYSTOCIA DUE TO SHORT CORD.

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BY

E. M. HALE, M. D.,

CHICAGO, ILL.

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THE interesting case reported in your last issue, where a short umbilical cord retarded labor, reminds me of a similar case occurring in my practice several years since.

The patient was a multipara, the mother of six children, all of which labors had been normal. At her seventh confinement the labor progressed favorably until the head was fairly upon the perineum, when, notwithstanding the strong expulsive pains no progress was made. I waited nearly an



hour before I applied the short forceps. I was surprised that my strong traction was required to deliver the head, and even then the body refused to be delivered unaided. When the trunk was withdrawn up to the umbilicus, I found the cord stretched tightly and extremely tenuous, with no pulsation. Fearing to exert further traction, owing to the danger to the child's umbilicus, which was already extending, the cord was tied one inch and a half from the body. When the cord was cut one pain expelled the whole body with considerable force, and the placenta immediately followed.

On measurement the cord proved to be only *nine inches long!* This is three inches shorter than Dr. Bliem's case, but not as short as some which he cites. In my case the child was living, and the umbilicus suffered no injury. In such cases I think it important that the cord be cut when found tense and pulseless.

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## THE VALUE OF THE CURETTE IN OBSTETRICS.

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BY

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BOSTON.

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SINCE its first introduction to the profession of Récamier, the curette has grown in favor, and its field of usefulness has become extended until now it holds an important place in the armamentarium of every surgeon and gynecologist. The specialist in obstetrics also appreciates its value, but the general practitioner, into whose hands come, numerically considered, nearly all the obstetrical cases, too often neglects its use. This is because the gravity of the conditions calling for its use is not fully understood, its value

as an instrument is not appreciated, or, the operative technique not having been learned, it is looked upon with fear.

Its use is not so free from danger that it can be used carelessly, for it has been the means of serious injury when in unskilled and reckless hands. In obstetrics there is less excuse for accidents than in gynecology, for no great operative skill is required to use it successfully and safely, but a perfect fore-knowledge of the work to be done and the exercise of judicial care are absolutely necessary.

Curetting is perhaps oftenest required at the hands of the gynecologist to remove morbid conditions resulting from the imperfect evacuation of the contents of the uterus at the end of a full term gestation, or at an abortion. If then the accoucheur can anticipate the gynecologist in the use of the curette, the patient may be saved months of suffering and invalidism, and escape continually impending danger.

A portion of retained placental tissue, although small, may set up inflammatory changes in the mucosa, and arrest the normal involution of the muscular walls. We then have the long train of symptoms incident to subinvolution and endometritis. The retained placental tissue may, moreover, be the nucleus of polypi or other excrescent growths.

The indications demanding the use of the curette at the hands of the obstetrician are briefly these :

1. The knowledge that some portion of the placenta is retained. To discover this the utmost care must be taken in examining the delivered mass, by spreading it upon a flat surface, the maternal side uppermost, and carefully coapting the uneven, broken, and pendulous portions. If this is done with watchful care it is quite improbable that the retention of even a very small piece can escape detection in a normally delivered placenta.

2. An odor of putrefaction on the napkins. This is

assuming that antiseptic precautions have been used to the extent of frequent bathings of the external genitalia, and gentle douching within the os vaginæ with sterilized water.

3. An unaccountable rise in temperature, with perhaps metritis, peritonitis, mastitis, phlebitis, or other indications of septic inflammation.

4. Frequently recurring attacks of flowing, together with delayed involution.

While some of these troubles may arise from absorption, through a lesion of the genital tract, of matter that has become septic within the vagina, they all so strongly urge the probability that something retained within the uterine cavity as to demand a careful investigation.

Should no placental or other normal substance be found within the uterus, it may be that the uterine wall at the site of placental attachment is in an unhealthy condition, the result of inflammation in the uterine tissues. This may be suspected if the placenta has been found diseased, or from the presence of pus upon or within the placenta. Here also the curette will be found most serviceable in removing the offending, unhealthy tissue, thus lessening the dangers from septicæmia.

While the condition of parturition favors the easy use of the curette, strict antiseptic precautions must be observed and the operative technique carefully and understandingly carried out. Without careful discrimination the softened, friable nature of the walls of the recently evacuated uterus may be mistaken for retained placental tissue. This error has been made and the scraping has been carried even to perforation of the uterine walls.

That curettage may be done easily and thoroughly, the use of an anæsthetic is necessary. The operator's hands and instruments must be made thoroughly aseptic, likewise the genital tract and uterine cavity. For this latter purpose I prefer the free use of water that has been sterilized by boiling, followed by a light rinsing with a solution of corrosive sublimate 1-2000.

Usually in these cases the os is so open and patulous as to make dilatation unnecessary. If, however, this is not the case, it should undergo rapid dilatation by the use of Goodell's, or some other like dilator.

The womb being brought well into the pelvic cavity, by means of manual pressure from above, or by traction from below with tenaculum forceps deeply imbedded in the anterior lip of the cervix, the index finger of the operator is passed into the uterine cavity well up to the fundus, and made to explore the entire walls and angles of the uterus. In this way portions of retained placenta and all irregularities, or nodosities, and disintegrating patches of the mucous surfaces may be readily discovered and located.

Now the finger nail, which has been made thoroughly aseptic, can often be used most effectively as a curette. With it the offending material may be carefully detached. Thus working under the guidance of the sense of touch, there is little likelihood of removing too little or too much. Sometimes the finger nail is palpably inadequate to accomplish the work. Then the curette must be used. Generally it is advisable to supplement the work of the nail with the steel curette, going lightly over the surface so as to make sure of thorough removal. Here it is that skill and good judgment are needed, not only in its use, but in the choice of the instrument to be used. Curettes are either dull, medium sharp, or sharp. Other varying characteristics do not demand our attention here. Probably there has been no instrument invented capable of doing more harm than the very sharp curette, which has an almost cutting edge. It would certainly be uncalled for as well as unsafe in the cases under consideration. The dull, or wire curette, at the other extreme, is likewise ill suited for this work. To remove firmly adherent tissue with it would require such hard pressure upon the uterine walls as might, from the bruising, provoke inflammation. The ultimate danger from this might be as great as the possible excessive use of the sharp

curette, or even allowing the septic material to remain in the uterus until carried away by nature's current, the lochia, or better still by the douche in the hands of the accoucheur.

Whatever curette is used, the degree of force required can only be estimated by experience and discerning judgment. It should always be the minimum necessary to accomplish the work.

The offending surface, then, having been located by the exploring finger, that portion, and usually that alone, should be carefully yet thoroughly scraped with the curette. If, however, the retained tissues show signs of putrefaction, it may be advisable to go carefully but lightly over the entire uterine walls, paying special attention to the angles. I prefer, however, to wipe the surface thoroughly with a swab of gauze saturated with some antiseptic fluid. As the curetting progresses the *débris* should be washed away with a douche of warm sterilized water. The irrigating curette which, being perforated from the end of the handle to the blade, allows a constant stream of water to be thrown upon the surface while the curetting is going on, has the advantage of convenience. I have never used it on account of the risk that it may not be thoroughly sterilized.

When the work is believed to have been accomplished, a final digital examination should be made to make certain that nothing has been left. This should be followed by a douche of sterilized water or some antiseptic wash. A solution of iodine, one or two drams to a pint of water, has the advantage of being an astringent as well as antiseptic. Some advise that the uterine cavity be now lightly packed with iodoform gauze; others, that a tampon of the gauze be placed against the os. It is my custom to dispense with both packing and tampon, fearing that as obstructions to free drainage they may be a greater source of danger than of protection and benefit.

## SOME DON'TS FOR BABIES.

BY

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WHILE walking beside the Niagara River just above the falls I was forcibly struck with the similarity between the rapid, restless rush of the river and our lives. The water would encounter a huge rock, dash against it, break and scatter or be churned to a foam, then flow on for a short space smoothly and calmly until another rock was met to be overcome. So we in our mad rush called living encounter rock after rock, it matters not whether large or small, the small ones often causing us more annoyance than the large ones, as it is the small things which make life miserable, especially to a physician. A few of the rocks one meets labeled *Don't* are the following:

The first don't struck was when I gave directions *not to wash the baby* at least for twelve or twenty hours after its advent in this lower sphere. When we consider its former environments the rude handling and immersion (for it is not short of a baptism) that it receives from the nurse are simply outrageous. Oil it well, wrap it in a blanket, and let it adjust itself to the new order of things. It will save all concerned many trials and much ill health for baby, consequently less care for the mother.

2. Don't allow the nurse and all the old women to pour down teas, good, bad and indifferent; each one will have the only one to be given, and poor helpless baby will have to suffer. Draw the line and draw it sharp at hot whisky toddy. Possible the baby will have a tendency that way, and it is most too early in the game to stimulate the sleeping lion.

3. Don't fail to give baby a drink of pure cold water—

it will often solve the question, What is the matter with baby, it is so cross?

4. Don't allow its clothes to be pinned too tight; try pinning a tight band around yourself and see how it feels; if you don't do something worse than cry it will be because you are not a man.

5. Don't begin medication unless absolutely necessary; think what a delicate little machine has been placed in our hands, and let us be careful how we handle the delicate, sensitive little one.

6. Don't allow it to be nursed every time it cries. Have stated times for its dining.

7. Don't allow it to be kissed by Tom, Dick, Harry, Polly, Jane, and Sarah, and everyone who sees it; it is not fair to take such advantage of the little helpless creature. Wait until it can have some choice as to who shall kiss it. This abominable practice of kissing is uncleanly, unhealthy, and above all unfair.

These are very simple things, but very important, not only to us as physicians, but to the future generations, for as we care for and cultivate the *best* in our mothers and babies, just so much better will the ever present and the future generations become; and the day will not be so far distant when more babies will remain with us longer, growing to manhood and womanhood, strong and sturdy, able to do battle for all that is highest, noblest, and best in mankind, living so that the world will be better for that living.

If we get the milk from a wagon we take our chance of getting milk from cows with some of the surroundings similar to the above described, and in addition have the milk delivered to us partially churned and from three to ten hours old. In Chicago and all other large cities it is shipped a long distance on the cars and has entered the first stage of fermentation ere it is delivered into the hands of the consumer. Granting that milk of as good quality, or

even slightly better, be furnished to the babe under twelve months old of ever so good hygienic surroundings so far as external cleanliness and pure air are go, let us examine the minutiae of its administration. We will often find but one bottle, which is used day after day until broken by accident. This is generally supplied with a rubber tube ten to fifteen inches in length (that the child may nurse while the bottle lies at its side, thus giving the mother a chance to work). At the end of the rubber tube in the bottle is placed a small glass tube four to six inches in length, at the other end is a small bone or hard rubber union, over which is slipped the nipple; with this substitute for a mother's breast is furnished a small bristle brush, which is said by all druggists to be sufficient to keep the tube in good clean order, and which the mother uses faithfully every morning whether in her judgment it is necessary or not.

If we cut off a small portion of this rubber tube after a few days' use and cut it in two longitudinally we will find an odor not unlike limberger cheese. There is no amount of rubbing on the inside of this tube now that will give it a clean pure smell. The decomposed milk has so permeated the rubber that it cannot be removed. I have examined the tube after the mother feels sure that it is clean and found it containing large curds of milk along its caliber and at the rubber union. Every swallow of milk taken by the child must pass through fourteen inches of this kind of tubing before it enters the alimentary tract.

There is not one stomach in ten of healthy adults that could take three meals per day under such unfavorable circumstances and not pay the penalty.

Many times have I known the above-mentioned conditions to be present, and when death seems to stare the little sufferer squarely in the face some substitute for milk is given instead of correcting the mistakes made in the administration.

Finally, don't be so sanguine about curing the patient



that you impress the family and friends that they are not very sick.

Don't be hasty in referring the diarrhea to the teeth, else you may overlook the real cause, which may be easily corrected.

Don't forget that bad sanitation is a prime factor in its causation, and have all garbage and filth removed and the patient's clothing and surroundings kept clean and pure.

Don't put a baby on a bottle until you are sure the mother's milk cannot be used.

Don't use milk from a cow fed upon garbage or distillery products, nor milk that has been shipped a long distance.

Don't feed a baby table food until it has teeth.

Don't prescribe one bottle with a long tube and nipple. Get one-half dozen, using three alternately, with a few short nipples that can be turned inside out and large enough to slip over the mouth of the bottle.

Don't give a substitute for good milk until you have convinced yourself that it has been administered properly.

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## UTERINE HEMORRHAGE.\*

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BY

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THE more I think over this very important subject, the more I am impressed with the fact that there is no royal road open, even to the homeopathist, by which to arrive at the specific for this or that case, as it presents itself to us as a morbid entity. By this I do not mean that

\* Read before the British Homeopathic Society, also published in the Journal of the Society.

the distinguishing characteristics of a case must not be carefully compared with the proving of an indicated drug, but that this must be done, *if possible*, in conjunction with a definite and explainable knowledge of the lesion present. If this be *not* fully possible—and there are many cases in which it is not—then the most that is ascertainable as to its pathology must be gained. The less there be, the less likely is our treatment to be effectual, and *vice versa*. The means to acquire this knowledge will, from time to time, be alluded to in the course of this paper. To refer here to the most important: There must be, in most cases, bimanual examination with or without an anæsthetic. The latter is to be preferred, in that sensation not being abolished the patient is able to localize pain, which is often of the greatest assistance to the examiner in enabling him to arrive at a conclusion. From examination thus alluded to, it is scarcely, perhaps, necessary to add, that with a few exceptions I exclude all cases of unmarried women and children, and refer to by far the largest proportion, occurring as they do in married people, after, say, the first two decades of life are passed.

#### ANALOGY BETWEEN MENSTRUATION AND THE PUERPERAL STATE.

It must have struck us all from time to time that there is a very close analogy between the well-known symptoms of menstruation and the puerperal state. While the virgin uterus is functionally dormant during three out of the four weeks, its *status quo*, is, of course, essentially the same as that of the unimpregnated organ after marriage. When, however, the catamenia are about to occur in either case, there arises a state of nervous erethism, shown by depression of spirits, some irritability, languor, and frequently sleeplessness. How this reminds one of the “morning sickness,” with its extraordinary caprice, and the odd

vagaries of appetite and thirst in the pregnant female, of which we could all furnish even ludicrous examples. Then, as the "period" is imminent, pain in the breasts or ovaries, or both, occurs, and a feeling is experienced as though the sanguineous discharge must have made its appearance, and yet it is delayed. How like the concomitants of the last months of pregnancy, when "hope deferred maketh the heart sick," and gloomy forebodings, the result of pain, tend to fill the mind.

Finally, just as the "flow" occurs, there is an absence of all pain; torpor and sleepiness perhaps take its place, and a feeling as though some miscalculation must have been made, when all at once this impression is falsified. Thus, too, as labor is about to commence pains cease, and there is a great calm. Thus, beneficent nature prepares the way for the supreme effort.

*Deductions from above.*—I have ventured into this, perhaps, fanciful analogy because I am profoundly impressed by the fact that, in the study of the diseases of women, and particularly of the errors of menstruation, we are face to face with very complex nerve phenomena, and not with the grosser organic lesions, and hence our remedies must be refined. We have all seen the deplorable results of "forcing the flow" by iron emmenagogues, so that when the unfortunate viscus has reluctantly consented to respond, the latter state of the patient has been worse than the former. Similarly, *mutatis mutandis*, the gain from the arrest of bleeding by coarse hemostatics may be of very questionable benefit.

Such cases, more especially the first, are essentially due to neurasthenia, and lend themselves to successful treatment only as that is based upon lines which go to supply nerve tone. There must, *e. g.*, for the young, be a cessation of the debilitations of school life, a removal from the crowded city to the exhilarating influences of moorland or seaside, and an addendum to the routine boarding school

perambulations, in the shape of the tonic of the gymnasium.

#### UTERINE HEMORRHAGE ASSOCIATED WITH PREGNANCY.

*Threatened Miscarriage.*—Uterine hemorrhage, viewed in its grosser aspect, brings one at once to a consideration—in which I shall be very brief—of *threatened miscarriage*. If a case is to be averted at all, my experience is that it is the most likely to be so by very minute doses of sabina. I call to mind two cases especially, in each of which there was the history of eight or nine miscarriages, and now there was the greatest anxiety that something might be found to avert a similar issue. In both I gave sabina 3x, with the happiest possible results. Rest, of course, was rigidly insisted upon, but as an *auxiliary*, a vastly important one, 'tis true. *Before* it had been employed, with equal persistency, but then it was the “be all and end all” of the treatment.

Of other instances of uterine hemorrhage occurring in the the puerperal state, I shall refer to two only, viz., “Missed abortion” and “missed miscarriage,” regarding them as instances of “pitfalls,” to use Mr. Knox Shaw’s phrase, rather than considering them at length, which would lead us too far afield. If there be one thing more than another that is of the utmost importance to bear in mind in dealing with the diseases of women, it is the possibility of *pregnancy*. It seems strange that such an obvious platitude should call for notice, but it does. What one is not prepared to find one does not search for, and we should hear less of grave errors in diagnosis if this possibility were more definitely kept in view. For us, who are followers of the great Hahnemann, this is the more important, for reasons which are but too obvious. For us, a mistake in diagnosis is not judged from the impartial standpoint of those who perchance once wrote in their copy-books side by side with ourselves, “*Hominis est errare*,” but is attributed to some

mental obliquity which is directly related to the therapeutic dictum which we profess. But to return. If the catamenia have ceased definitely for a certain period of time, and there be other well-known signs consistent with the possibility of pregnancy, it behooves us to institute an exhaustive inquiry as to whether we have not pregnancy to deal with, perhaps alone, or perhaps plus some morbid condition of the uterus or in its neighborhood.

#### CASE OF CANCER WITH SCIATICA.

By an easy transition I now come to speak of a case in which the important sign of uterine hemorrhage was so hidden as well-nigh to lead me to a grave error in diagnosis, as perhaps its obscurity had done in the case of the previous medical attendant.

Mrs. S., aged forty-three, deaf and dumb, presented herself at the Dispensary with a very intelligent companion as interpreter, and through the latter narrated a sad tale of woe respecting the intense pain she suffered in the left thigh. I narrowly inquired into the case, but was unable to form a more definite diagnosis than that which had already been made, viz., that she had *sciatica*. Thus the case was treated *symptomatically*, and as such belongs to a class which, I freely admit, humiliates me more than any other. In spite of the digression I must add that, so far from taking a pride in treating a case in this fashion, as some of our school I believe do, it fills me with shame and confusion. Instances of course occur, when to attempt refinements of diagnosis would lead one into the fields of speculation or romance, and this is to be shunned. I go so far, however, as to say, that with the gynecologist such cases ought to be rare, and this especially applies to those of uterine hemorrhage. The prime cause must be diligently delved for. To return, however. The patient derived no benefit, and I was told by the friend that the nights were so distressing that, on a recent occasion, she

had, for some unexplainable reason except that she had great faith in its virtues, administered a large dose of castor oil. "That night," added she, "Mrs. So-and-So slept the whole night long." "If this is the case," I said to myself, "there is here some mechanical pressure in operation." I had already made careful inquiry *re* menstrual function with negative result. Prosecuting it now with more vigor, I made out that there was *some excess* of the flow, accompanied by some irregularity. I at once examined her, and found unmistakable cancer of the uterus. Here then, an "excess of the flow," meant carcinoma sufficiently far advanced to have involved the sacral plexus, or some of its branches. Perhaps, had the patient been in possession of her faculties, one might have elicited this crucial information earlier.

#### CASE OF PROLAPSED UTERINE FIBROID.

Some two years ago I was stopped in the street and requested to go and see a woman who was "bleeding to death," I think the expression was. I found the wife of a tradesman, aged about twenty-six, lying in bed with profuse bleeding from the vagina. Her friends informed me that, being of a very retiring disposition, she had concealed as far as possible the fact that she had recently had repeated attacks of "flooding," forcing herself to attend to her household duties as much as she could. She had one healthy child of six or eight months. On introducing my finger within the ostium vagina it at once came upon a hardness which felt very like a child's head. On turning round the bed and separating the labia, I was able to some extent to expose this protruding substance to the light, when I found it smooth, glistening, and purplish-red in appearance. It protruded through the os uteri, which was stretched to about the size of a five-shilling piece, and was so tense that I could not ascertain the attachments of the lump above. I had no doubt the case was one of prolapsed fibroid.

Hamamelis was prescribed, with a strictly recumbent posture, and hot water irrigation was ordered to be employed, if necessary. Time passed, and improvement ensued so far as arrest of hemorrhage was concerned; still, the tumor remained but little, if at all, altered. From time to time the patient suffered from very copious yellowish watery discharge, which was very offensive and distressing. Moreover, dropsy of the left leg became marked from pressure on the intra-pelvic veins. I felt strongly that the only chance of saving this patient's life was to strangulate the tumor, but before doing so I sent her to a well-known surgeon, who placed her under chloroform and examined the attachments of the growth, with the result that he came to the conclusion that they were so intimately amalgamated with the structure of the fundus, that it was undesirable to attempt surgical interference. He advised the use of ergot subcutaneously. I dissented from this opinion, but practically my hands were now tied. The ergot did no good, and finally the patient went into the country for change of air. While there she benefited sufficiently to be able to take some exercise, and on one occasion so far exceeded the limits of her small powers that, as the informant told me, the mass came down between her thighs, and she was carried home, the nearest doctor was summoned, and she died collapsed in a few hours. What, then, are the practical lessons to be derived from this disastrous case? In such an one, we owe a duty to the patient to give her, in the ordinary phrase, "a chance." Here, I believe, there was more than "*a chance*," and I shall never cease to regret that I did not put a corkscrew into the mass and drag it down as far as possible, then encircle the neck with a thickish platinum wire, such as I use for large growths, connect it with the battery, and gradually burn through the attachment. Probably there would have been no hemorrhage to speak of. The stump thus charred, and its vessels thrombosed, would present a non-absorbent surface. It should

then have been dressed with iodoform gauze, and the vagina packed with the same material. Thus, I venture to think, there would have been much probability of saving life. The *cold* snare I should not feel anything like the same confidence in.

#### UTERINE FIBROIDS IN GENERAL.

This leads me to refer to the treatment of uterine fibroids in general. I have spoken elsewhere of some of the remedies indicated in certain circumstances; it remains only to refer to the induction of an artificial menopause by removal of the ovaries and tubes. I leave those who can speak authoritatively upon this point to discuss this matter, merely observing that where enucleation, after dilatation, cannot be accomplished, and where the indications for removal, viz., free mobility of the uterus and moderate size of the tumor, exists, I, for one, think the operation is to be upheld by all means.

#### CASE OF OVARIAN PROLAPSE.

I desire now to refer to a case of uterine hemorrhage with prolapse of the ovaries, and other symptoms which I will immediately detail, a case which, in spite of its very unfavorable signs as regards the likelihood of amelioration ultimately yielded to extremely copious hot water irrigation.

Mrs. H., aged about thirty, has not been well since her youngest child was born, a few years since. Shortly afterward she began to suffer from bearing down and copious monthly periods, the former aggravated by any exertion such as pushing a perambulator, against which she was repeatedly warned. This state of things continued better or worse for a long time, and finally she sought advice. I found the uterus enlarged and prolapsed, the vagina shortened, pocketing, and thrown into folds, and the ovaries tender and prolapsed.



Pessaries were badly borne ; in fact, with the exception of a Zwanke's she could not bear one at all. Thus matters were partially and imperfectly relieved, and when I was away from home on one occasion she was seen by a surgeon, who, in view of the condition of the ovaries, advised removal of them, and sent the patient to London to a well-known specialist for confirmation or otherwise of his opinion. His advice was to temporize, and in the mean time to employ tremendously copious irrigation of hot water, several gallons to be used at a time. I may incidentally remark that I had employed this method already, but to nothing like the same degree. Time passed, and I am bound to confess, that at length, this most ponderous treatment effected a satisfactory change, in so far at least as to lead the patient to-day to express herself as "nicely," whatever that may be held to imply.

Permit me here to refer to a difficulty which I have often had, and which must be common to all my brethren, and upon which I should like to hear an expression of opinion. My patient was one of those who bear restraint badly. Mrs. H. had at times suffered cruelly from so-called "depression," which was liable to considerable aggravation by the restraint necessary to her state. Some patients in similar circumstances are the victims of restlessness which is well-nigh intolerable, so that one cannot urge rest for them either, with unmixed benefit.

Such women are the exact antithesis of those who take invalidism well, and with regard to whom the doctor must be on his guard, lest by chance they fall into the state of the chronic, hysterical invalid. Those first referred to are of the lively neurotic type, unselfish, full of healthy plans for others, and are thus of an attractive disposition—women, in short, for whom the world is infinitely the better. They say, as one did a few days ago, "Whatever you do, don't keep me in bed, I cannot bear it," and they cannot. They demand and require a variety of intellectual food, and an

ever-varying environment. A graphic picture is drawn of this type of person in Chas. Reade's "Never too Late to Mend," in the case of Robinson, incarcerated in the dark room. It well repays a study.

#### CAUSES.

I now come to say a few words upon the *causes* of uterine hemorrhage, and observe at the outset that within the brief space of this paper it is obviously impossible to give anything approaching an exhaustive list. Moreover, to attempt to tabulate them properly would be equally out of the question.

Among the great variety of causes, I desire to glance especially at a few which have come more prominently perhaps than others within my own personal observation and experience. They are briefly :

(1) Uterine engorgement and hyperplasia, the result of subinvolution.

(2) The first and last "climacterics," to use Thomas' phraseology, viz., puberty and the menopause.

(3) Want of fresh and pure air, especially when the temperature of the apartment is maintained by lighted gas.

(4) Tight lacing.

(5) Wearing too many and too heavy clothes, the injurious effect of which operates in two ways, viz., (*a*) by producing a condition of muscular and nerve exhaustion by their weight, and (*b*) by inducing pelvic stasis by their constriction at the waist.

(1) *Subinvolution*.—In these days of high pressure which tells so injuriously upon women, perhaps even more than upon men, no wonder that the subject of an abortion or miscarriage should dispense with that beneficent restorer *rest*, long before its work can have been half accomplished. When the imperious calls of home and family summon the mother to activity she obeys them with an unselfish devotion, which, however, does not lift the burden of

responsibility from the doctor's shoulders, but rather redoubles it. It renders his duty the more imperative to insist upon a sufficient length of time in the recumbent position.

It is, however, under the head of *treatment* that I have something to say upon this cause of uterine hemorrhage.

With regard to the *second cause* mentioned, viz., *excessive bleeding at the "climacterics,"* I have also but little to say. Under *treatment*, I might say much, but as we have had recently in the pages of the *London Homeopathic Hospital Reports* a fairly exhaustive review of this subject, it were idle to travel that ground again, especially as, in regard to "climacteric" bleedings, a careful study of the clinical features of the individual case is the key to success in dealing with it. I mean, of course, when there is no actual organic lesion to be found.

*The third cause, viz., want of fresh and pure air, and the injurious effect of lighted gas for heating purposes,* demands a note. I have recently met with some cases which are explainable only on the assumption mentioned, and are practically incurable until the cause be recognized and removed. When it *is*, the indicated remedy can do good, but *until* the remedy is thus "*liberated*," shall I say, it is valueless.

(4) *Tight Lacing*.—At the risk of dwelling upon a well-recognized, and, as some may say, a well-worn cause of uterine hemorrhage, I must ask your indulgence while I again call attention to this, for it is of the first importance viewed in the light of the pathology of the morbid condition we are considering. Moreover, it does not appear to me that the teaching of physiology, so much more now in vogue than formerly, has so far tended to diminish the evil in any conspicuous degree. To glance at a *typical case*:

M. W., aged seventeen, was quite well till three years ago, when she began to complain of pain at the "periods," so that her doctor had to give her a "draught" every month. The

catamenia first appeared when she was twelve years of age, and were at that time painless. After a time she began to lace tightly, calling in the aid of a young friend to assist in pulling in the strings of her stays as tight as it was possible to do. Since this time she has always suffered from constipation, and intense pain at the "periods." The latter is mostly referred to the *left* ovary, and lasts six or eight hours. Moreover, the flow is excessive. Examination revealed the uterus acutely retroflexed, and jammed in the pelvis. Under treatment she gradually but slowly improved, the reflex nerve phenomena being the most difficult by far to combat, begotten as they were by a misappropriation of the nascent nerve forces of puberty. Instead of their being permitted to accomplish the designs of nature by furthering the developmental changes incident to the first "climacteric," they have, so to say, been deflected at a tangent, and in this case the result has been a choreiform or purposeless chain of phenomena, mostly emotional. To such we give the name of *hysteria*. Inasmuch, however, as the uterus has been so hardly dealt with in such cases, it becomes us to consider the antecedent events which have brought about the lesion, when it is abundantly apparent that the uterus itself is the *last* organ to blame.

I am greatly impressed by the part played by tight lacing in a class of cases which may be briefly illustrated as follows :

A woman between, say seventeen and thirty years of age with anæmia written in her face, seeks our advice for pain about the epigastrium, or one or other hypochondrium. It may or may not be affected by food ; sometimes it is aggravated, sometimes relieved. The bowels are costive. On asking to see the tongue we are struck by the fact that it is red, shining, glazed ; yet, withal, there is a certain degree of underlying pallor. The catamenia are painful, and sometimes excessive. If menorrhagia exist, though this is not the rule, our first thought is, what relation, as regards cause

and effect, do it and the anæmia bear to one another? It is, however, unnecessary *exactly* to determine, for one glance serves to detect the constricted waist, and this will unravel all the mysteries of the case in hand. So common has this group of symptoms come to be associated in my mind with tight lacing, that I picture involuntarily a displacement of the abdominal viscera, more particularly, I believe, of the stomach, to say nothing of the jamming in the pelvis of the organs therein. I almost automatically begin treatment by insisting upon a loosening of the construction *cito tuto et jucunde*. Without this, which is the keynote of all, the treatment is vain and fruitless. *With* it, arsenicum, sometimes iron, sometimes chin. sulph., will produce a change in a short time which is little less than marvelous.

#### TREATMENT.

I now glance at the question of treatment of uterine hemorrhage. Incidentally this has already been referred to in dealing with the clinical cases brought before your notice.

The *medicinal* treatment has, as already remarked, been somewhat fully discussed in the papers of the last volume of the *London Homeopathic Hospital Reports*. I make no apology, therefore, for not referring to it more fully here.

It remains, however, to speak of an *auxiliary measure*, which I have found of great service in dealing with some cases, especially with those coming under the head of *sub-involution*. In such we have to deal with an enlarged and heavy uterus low down in the vagina, one which tends to topple to the right or left according to the position which the patient assumes.

How is the uterus in such cases best maintained in the right position? and how is the menorrhagia of which it is the object, the best controlled? To answer the second question first: The endometritis will require the local application of iodine, iodized phenol, or carbolic acid, which

will result in a renewal of the mucous membrane, and hence, so far as it is concerned as a factor, arrest the excessive discharge. Sabina, administered internally, will, moreover, materially assist. But what will best support the enlarged and heavy uterus is, so far as my own experience goes, the inflated india-rubber ball pessary, such as I had the honor to describe at Northampton last year.

It should not be kept in very long, a week or two is sufficient; it may then be replaced by the india-rubber ring which will have to be worn for a lengthened period probably. The posterior wall of the vagina is retracted by a Sims speculum. The india-rubber ball, collapsed, is held in the blades of an ovum forceps, and when well greased and finally smothered with iodoform it is slipped into position, and then well inflated by air. I have learned the advantage of using a smaller-sized ball than formerly, and of retaining it, as stated, but a comparatively short time, and have been much gratified with the perfect result obtained. Rest in bed or on the couch is at an end. The patient can once more get about without any harm resulting from again resuming the vertical position; nay, a positive and great gain is the result of a renewal of muscular activity, for the uterine attachments gain in tone *pari passu* with that of the voluntary muscles. Moreover, there is now no longer the distressing sense of weight in the pelvic region which was so conspicuous before.

#### CASE OF GONORRHEAL SALPINGO-OVARITIS.

In conclusion, gentlemen, I desire to bring under your notice a case which has already been published in the *London Homeopathic Hospital Reports*. If on that account I ought not here to refer to it, my excuse is that I am very anxious to hear the opinions of my brethren upon it, more particularly in reference to treatment, because upon the advice we give in this regard so very much depends, for weal or woe, to our patients.

Mrs. X., age about thirty, wife of an army officer, has been ill for twelve years, with what has been called "catarrh of the womb." She has been married four or five years, and has passed most of that time in India. She has one child, a fine, healthy girl of two and a half years. Patient suffers from profuse menorrhagia, and constipation is a marked and painful symptom. There is intermittent, and at times very profuse, leucorrhœa. She has lately been under treatment by a well-known medical man in London, and has had caustics locally in abundance, and ergot internally. On September 25 last I examined her and found the cervix notched on both sides; the sound showed the uterus to be three inches in length, its axis was straight, and the whole organ tended rather to the right side. There was tenderness in both ovarian regions. I diagnosed the case as subinvolution of the uterus, in part caused and maintained by the erosions spoken of, and ovarian inflammation. The *treatment* consisted of sepia, and glycerine and carbolic acid tampons. For the constipation an appropriate diet was ordered. Improvement at once ensued, and when the next "period" recurred, though the quantity was about the same as usual, the general state of the patient was obviously better in every way. I now gave *lilium tig.* 2x, with marked improvement as regards the leucorrhœa. Thus matters continued on the ascending scale, until one day I was suddenly summoned by telegram, and on arrival found intense pain and tenderness in the right ovarian region, considerable pyrexia, and other signs of acute peri-oöphoritis. This was sufficiently disappointing, not to say puzzling, and I set myself at once to inquire as to the cause of the turn affairs had taken. On careful inquiry I learned that a month after the child was born in India the patient suffered from what I had no doubt, from the symptoms described, was an attack of acute gonorrhœa. Here, then, was a case of gonorrheal ovaritis, and probably also salpin-

gitis, with, at the present juncture, implication of the adjacent peritoneum and cellular tissue.

I need not detail the history of the case for the next few weeks; it was one of acute suffering and some danger. The specific remedies relied upon were merc. cor. and bryonia; belladonna suppositories in the rectum to ease the intense pain, and occasionally some nepenthe with a like object. A steady convalescence ensued. When the case was sufficiently recovered I again made an examination and found a fixed uterus and, as before, a tender right ovary. If now my conjecture, *re* gonorrhea, were correct, of which I had no doubt, the patient was in jeopardy of a like attack which might prove fatal, and that, perhaps in the near future. I therefore unhesitatingly advised removal of the adnexa, and was greatly relieved to find that Dr. Burford, who came down to Plymouth to see the case, entirely concurred. This radical advice naturally alarmed the friends, and for corroborative purposes they sought opinion outside our school, in which I concurred.

I need not enter into particulars, except to say that the first opinion was to the effect that the symptoms were due to a fibroid, and the second—that of a well-known specialist in London—was entirely confirmatory of Dr. Burford's and my own views, except that in consequence of the marked improvement which had taken place in the patient in the interim, delay as to operation was advised, and that, in the event of its performance, one set only of appendages should be removed. Thus the matter rests, and whether the advice to act with promptitude or to delay until perchance another attack occur, be the right one, I can only say with Dr. Burford, "*Dies declarabit.*"

In conclusion, it is necessary to make one or two comments. After the patient was convalescent from the acute attack described, the husband first sought my advice for gonorrhea, which, as before shown, had, until that time, been a matter of conjecture only.



And now let us consider for a moment the question of operation. What future developments, if any, are we likely to have in this case, and what do they portend as regards the patient? A careful study of the history of such cases convinces me that, speaking broadly, *recurrent peritonitis* is almost certain to take place sooner or later; the *status quo* is essentially unstable. Statistics show that in patients with suppurating tubes these lead to death in about one-fourth of the cases (Cullingworth). What of the mortality after operation for the removal of the adnexa? The same author gives this as from five to ten per cent., according to the skill and experience of the operator. Then as to the advice to delay. Why wait for another attack of peritonitis, which may be fatal *per se*? If not so, haply, it would immensely increase the difficulties of surgical interference, and correspondingly diminish the chances of recovery.

Another feature of the same advice was to remove one set only of appendages.

It has been abundantly proved that, though one side start the mischief, both sides are involved in the inflammatory adhesions, and Lawson Tait has conclusively shown the fallacy of removing one set of appendages only in these cases. I have already drawn attention to the fact that this patient first came under my care for *uterine hemorrhage*—in fact, this was her “complaint.” And here I would observe that this is a very usual symptom in such cases, a point which, if lost sight of, might cause us to be led far afield.

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DR. BURFORD showed a uterine fibroid which he had recently removed. The patient had been under medical supervision for some years, but latterly the period began to occupy almost as long a time as the interval, and as the tumor was, within the last six months, rapidly growing, the time had come for radical alteration of treatment. So

the patient came into hospital and the operation was performed. It was the toughest operation, so far as regarded the removal of a uterine fibroid, that he had ever undertaken. To his own and the patient's delight the highest temperature for the first week was  $99.8^{\circ}$ . The present week was the fourth after the operation, and the chart was a most satisfactory one. On listening to the paper he had been reminded of the axiom of the great German physiologist who used to insist upon teaching all his pupils that it was far better to observe than philosophize. The four clinical cases were worth a great deal of philosophizing on the subject; every case had been considered on its own merits, and with reference to its particular symptoms. He made bold to say that there were certain cases of uterine hemorrhage in which no remedies hitherto were of any permanent avail. In dealing with a case of uterine hemorrhage the first thing they had to find was the cause. There were many causes of uterine hemorrhages that were extra-uterine in character. Extraneous causes often set up a uterine bleeding which was sometimes almost intractable. It was possible to have very many lesions of the ovary, not those of the ordinary ovarian tumor, setting up intractable uterine hemorrhage. He had had a patient recently, over forty, who had been suffering from uterine hemorrhage for years. He found on operation the expected sclerososis of the ovaries, the removal of which completely cured the hemorrhage.

DR. NEATBY said there were two classes of cases he should like to refer to; one was uterine hemorrhage occurring in young women from the age of eighteen to twenty-five. He did not mean by uterine hemorrhage exactly what Dr. Reed did, *i. e.*, he referred to menstruation, but menstruation which was obviously in excess, in other words, which was distinctly pathological. Within the last few months he had seen quite a number of these cases, mostly either in the students at college working for their degrees, or tutors—ladies who had had a large amount of mental work. In

four out of five cases which he had particularly in his mind he found upon examination by the rectum that one or both ovaries were distinctly large and tender; the ovaries had taken part in the general irritation and had been the secondary cause of hemorrhage. He considered those were a class of case by themselves. Then there were some troublesome cases which came to them after the ovaries had been removed, to bring about an arrest of hemorrhage or to relieve pain. In some of those cases there was a condition of endometritis, which was probably due to the previous state of the uterine adnexa, and had not been locally treated beforehand. The removal of the cause had not cured the local condition. He thought that local treatment should be tried if there was any reason for doing so. With respect to remedies, very little had been said about them. There was one very important one, viz., hydrastinin, which was introduced three years ago, first in Germany, and a very short time afterward in this country by Dr. Burford. Hydrastinin had met with varied success in the hands of different men. In his own case it had been fairly satisfactory, but it was necessary that it should not be used higher than 2x or 3x. The expense of it made it often impossible to continue it, but that remedy and phosphorus had been in his hands of the greatest possible use in the cases he had referred to, viz., students who had uterine hemorrhage associated with ovarian irritation. Hydrastinin just before the period and phosphorus in the interval had given the greatest possible satisfaction, and enabled the patients who were, perhaps, working up for an examination and almost breaking down to go through satisfactorily. He had read recently (in the last issue of the *Zeitschrift f. Geburts. und Gyn.*) of investigations with regard to hydrastinin which showed that it had practically cured all kinds of uterine hemorrhage. He was afraid, however, that they could not judge much of that, because it was impossible to say what the condition of the patient was. In simple menorrhagia,

where there was no local diseased organic condition to be found, the success was very satisfactory, amounting to eighty per cent. of the cases treated. The relief lasted from one to three years. The observations were extended over a period, in some instances, of from  $2\frac{1}{2}$  to 3 years, and there was no relapse for that length of time, although the hydrastinin had not been continued. Forty-five per cent. of the cases of subinvolution were very distinctly ameliorated, if not entirely cured, and in those cases also the results had been lasting.

DR. DUDGEON said it was often said by physicians that a good many cases were cured by them upon which surgeons would otherwise operate, but sometimes the surgeons had the best of them. He had treated a lady affected with menorrhagia, and had given her every possible remedy that homeopathy could suggest, including hydrastinin, but without avail. As she was the wife of an allopathic doctor, she had previously been subjected without benefit to all the known remedies of his school. A surgeon was called in and the uterus curetted, which effected a perfect cure. The patient was now quite comfortable, only having very moderate menstruation and no suffering at all. So there homeopathy was beaten and surgery was triumphant.

DR. MORRISSON said that fifteen months ago he saw a patient who had had a small uterine fibroid removed for excessive hemorrhage. She had been for three years under allopathic treatment, and had been almost completely poisoned by ergotine. Following the operation, some three or four days after each monthly period, she had hemorrhage. Then hemorrhage recurred and she suffered intense pain. She obtained considerable relief from the pain by six months of Mattei treatment, but the hemorrhage still continued to a dangerous extent. When she came under his (Dr. Morrison's) care, the hemorrhages recurred about every three weeks, with attacks of severe pain in the left ovarian region. Three or four days after the cessation of the usual

hemorrhage she passed a very small quantity of arterial blood, and on each of these occasions she was threatened with collapse. Under the use of secale 3 and various other remedies, carefully selected, there was considerable improvement, but the case was not altogether satisfactory. The mental symptoms then directed his attention to chamomilla, and under chamomilla 3 the patient not only improved and left her bed, but got out for drives. In January last she went to the seaside, and at the present time was getting about the midland districts in comparative comfort.

DR. GOLDSBROUGH said that threatened miscarriage was met with, at frequent intervals, by general practitioners, and his experience had not been a favorable one with regard to the use of remedies for its prevention. There were two, however, which certainly had a good effect, one mentioned by Dr. Reed, viz., sabina, and another which he thought had a better effect still, if the patient was seen early enough, viz., arnica. As a rule, there was some traumatic cause, perhaps of a slight character, which was the exciting cause of a miscarriage, and in these cases arnica had a very good effect, but if not seen until there had been pain, his experience of any remedies had been of a very uncertain kind. Dr. Burford would recollect a case of fibroid tumor which he (Dr. Goldsbrough) had sent him two years ago, which he thought would require early operation—the case of a domestic servant between thirty and forty years of age. The pressure symptoms were being developed very strongly, and the patient was very uncomfortable; she could hardly pass water, and the pressure on the rectum likewise was very bad. Dr. Burford advised him to temporize for a while. He put her on 3- or 4-drop doses of the mother tincture of secale, and she had been taking that medicine ever since, and at the present time she did not suffer in any way whatever from the pressure symptoms. He had forgotten to mention that the hemorrhage had been very profuse,

but the patient did not suffer from that now, and altogether her health was very much improved. It might be necessary for him to hand the patient over to Dr. Burford later on, but at present there was no indication of it; and of course the patient was rejoiced at having escaped such a severe operation. With regard to hydrastinin, he had used it in the trituration suggested in vol. ii. of the "London Homeopathic Hospital Report," and had found it of considerable benefit. He thought the cases where hydrastinin was indicated were where there was a considerable amount of exhaustion of the vital powers on account of the hemorrhage. It seemed to stay the hemorrhage and make the patient feel better, and generally the improvement so far had been maintained. He had generally given it in the second decimal trituration, as suggested in the account given in the Reports, but in one case recently he had tried the fourth decimal because the patient complained that the medicine was trying her. Whether there was any ground for that he could not say, but at any rate she was maintaining great benefit from it. The lessons he had learned from the symptoms of uterine hemorrhage had led him, if he could not discover the cause, to hand it over promptly to the special physician for an exhaustive examination.

DR. MADDEN (chairman) said with regard to the case on which Dr. Reed especially asked their opinion he did not think that any of them would wish him to have acted other than he did in advising operation, and he (Dr. Madden) hoped that it would be undergone speedily, so as to bring the patient out of danger at the earliest possible date. With regard to the method of treating threatened miscarriage, Dr. Reed had not mentioned the medicine which in his (Dr. Madden's) hands had proved most successful, viz., *caulophyllum*. He could recall two or three cases where rest alone had failed, and where rest combined with *caulophyllum* had carried the patient through the critical time, and living children had been born, and everything

had gone on satisfactorily. He generally gave it in the second decimal, 5-drop doses three times a day.

DR. CASH REED, in reply, said that, with reference to the question of extra-uterine causes of uterine hemorrhage, he had not specially referred to that, for the very simple reason that it involved so much. Pathological menstruation had been much discussed of late, and therefore he had not referred to it very particularly.—*Jour. Brit. Hom. Soc.*

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## ● EDITOR'S TABLE. ●

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IN regard to the immediate repair of the lacerated perineum, it has often been said, and truly said, "That very few physicians know how frequently laceration of the perineum takes place in the practice of the ordinary every-day physician." And this is so because they do not take pains to look for it, and possibly have not been trained in effective methods of making such an examination as would determine the existence of a laceration. In all cases whether the laceration is suspected or not, the patient should be put in the proper position and examined. The usual position in which a patient lies in bed after childbirth is such as to hide the laceration, because the parts naturally coapt, unless the tear is very extensive. The Sims position is probably the best as this enables the accoucheur to make a ready examination. Very small tears will take care of themselves, because the parts, now being swollen, as they come back to natural size will reduce the apparent size of the tear. If upon examination it seems to be not more than half an inch in length, and we have assured ourselves that the internal injury is not greater than this, we may well leave it to nature. However, it should be always well remembered that every raw surface is a point of danger for the entrance of septic germs. Childbirth fever is aseptic fever, for this reason unless all the surroundings of the patient are hygienic, and the patient can be kept absolutely clean, it is better that even a half inch laceration should be immediately repaired. The operation

is so small and requires no more skill than the threading of the needle, and only a moment or two of time, provided the physician knows his business. Even in these very small tears it is desirable to open out the torn surface so as to expose it thoroughly, and then taking a piece of absorbent cotton, wet in calendula tincture, thoroughly cleanse the wound. The part should then be neatly coapted and retained in place by one or more catgut sutures. So treated these small wounds will heal promptly within a week, and the patient, as far as the perineum is concerned, be as well as ever.

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**B**UT unfortunately most cases are not as simple as this. The tear is apt to run up along the interior surface, and is frequently irregular in form. However extensive the tear may be it should always be cleansed with the calendula solution, which, however, must not be used in full strength if the wound is extensive. When the tincture is used without dilution, I have seen extensive swelling occur, which, however, does no harm as far as the healing is concerned, in fact rather hastens union by first intention. But it might, in some cases, be so great as to actually block up the outlet to the vagina, and cause the patient unnecessary discomfort. After the part has been cleansed, and any projecting tissue cut away so as to leave a neat and regular surface, the parts may be drawn together by various means according to the extent and nature of the rent.

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**I**T should be the rule of practice that all lacerations of the perineum great or small should be attended to immediately, or within a few hours after they occur. The repair may be made even on the next day, and the wound heal nicely without suppuration, but such delay should never be permitted when it can be prevented. The sooner the operation is done after the child is born the better the results will be as a rule. In the discussion on this subject at the Denver meeting of the American Institute one well-known physician said, with much emphasis that : "Within one hour after labor was too soon to perform any operation for the repair of the lacerated perineum." Now it may be there are cases of great exhaustion, and in which also there is unfortunately



an extensive laceration, in which case an operation may well be delayed, and in which better results may be anticipated from delay, but we must strenuously object to being classed among those who are said to be guilty of meddling midwifery, because they at once repair these accidents. In most cases it causes the patient less pain and discomfort if the operation is done at once. The apathetic state in which she is, and the local anæsthesia of the parts caused by pressure, are reasons why an immediate operation is better than delay. This anæsthesia or benumbing of the parts is a species of bruise which is more quickly overcome, if the parts are stimulated by being cleansed and brought together in their original position. The obstetrician who thus repairs without delay all injuries to the perineum is not guilty of meddling midwifery, but he would be guilty of negligence if he failed to acquaint himself with the actual conditions of the parts and at once proceeded to mend them. Under ordinary conditions it is never too soon to perform an operation of this sort, and while the physician must always use his best judgment in determining what he will do in each individual case, and while he is responsible, and he alone, to the patient and her family for the proper treatment, and so cannot have any fixed rule from which he may not deviate, yet this rule of immediate repair is as invariable as any rule of practice can be.

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OF far greater importance as a matter of professional skill, however, is the ability to prevent lacerations, rather than to mend them. The repair of a lacerated perineum is a matter of hand-work, and is as mechanical as the making of a box or the carving of an umbrella handle. The prevention of laceration requires a kind of skill of an altogether different order. There is no form of preventive medicine more interesting, more useful, or more worthy of the physician's attention than that of preventing the so-called "accidents of labor." These are really accidents in so far as they ought never to occur; if the woman has that careful and skillful attention during the term of pregnancy which she should have, these accidents would not occur. But even leaving out this larger view of the subject, and merely confining ourselves to the parturient, most of these accidents are due to haste and lack

of care. Many physicians pride themselves on the rapidity with which they can turn off a labor case. A great deal is said about not allowing a woman to suffer unnecessarily, but if a man understands his materia medica sufficiently well to deserve the name of physician, he can easily prevent unnecessary pain by giving the indicated remedy. No class of cases are more directly under the control of the physician than these cases of protracted and abnormal labor. In every case, probably without any exception whatever, the condition simulates the well known characteristics of one of our drugs, the administration of which will quickly relieve the case of its abnormality.

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THE laceration of the perineum may very largely be chargeable to the medical attendant. He is unwilling to give the necessary time; he has perhaps a pride in turning off cases quickly; he has perhaps other cases to which he wishes to go; he is perhaps infected with the idea that he must make himself useful. Often the greatest use to which the physician at this time can put himself is to simply stand and wait, but this waiting must not be the result of, nor the opportunity for, inattention. He should be as watchful as a hawk is said to be when searching for its prey, but let him keep his hands off unless he is quite sure that to act at all is to act wisely. While there are many exceptions to the rule, and it is in these exceptions that the physician has the opportunity to display his skill, it is nevertheless true, and always true, other things being equal, that a slow delivery is a safe delivery. Dilatation proceeds best when necessary time is given to it, and for this reason the woman should not be hurried. She naturally shrinks from the coming ordeal, and delays it. In her own interest, and in the interest of the child, this is a useful precaution. When the real time comes she more frequently needs to be cautioned not to force too much, rather than to be urged on. The physician who, instead of restraining her, takes every means to encourage her to bear down, when dilatation is occurring but slowly, will be apt to have a laceration to attend to subsequently. Especially will this be true if, in addition to urging the woman, he uses manual or instrumental force himself. Delaying pains, weak pains, and other abnormalities can be overcome by the

homeopathic remedy, but extrinsic help cannot be so reached. It should be the physician's purpose to help Nature to help herself, rather than to supersede her ; and he will find this help more often in his medicine case than in his obstetric bag.

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THE use of ergot after labor was discussed at the recent meeting of the American Institute, by Dr. Ordway and others, and the opinion expressed seemed consonant with the facts as regard to ergot as now understood. Ergot should not be ostracized in obstetrical practice. Every drug has its place, and the place for ergot is after, not during, labor. There are undoubtedly occasional cases in which the life of the parturient woman is lost because of the lack of the timely use of ergot. It is only very rarely needed. It possibly never would be needed if the case was treated from the beginning along purely homeopathic lines ; but lacking other means at hand, it is a timely and useful remedy where bleeding continues because of foreign substances retained within the womb. In many cases other remedies more truly homeopathic are pointed out clearly by the symptoms present, but some cases are obscure, and have not any symptoms apparently but the objective ones. In these ergot has a place. Possibly the best form in which it can be used is Hayden's Styptic, which contains ergot as the main constituent, the others being cinnamon and erigon tinctured in the best French brandy.

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THE desirability and advisability of thoroughly cleaning out the uterine cavity very soon after the expulsion of the embryo or fetus was dwelt upon by Dr. Sheldon Leavitt at the recent meeting at Denver, recalling his remarks made at the meeting at Washington two years ago. A very large number of the ailments of woman date back to a miscarriage. It has been considered good practice, and still holds good with many practioners at the present time, to delay dilatation and leave the expulsion of the embryo, or of the retained secundines, to nature. Now, it is undoubtedly true that it is advisable to get rid of whatever remains in the uterine cavity as soon after the expulsion of the fetus as possible, and as soon as the condition

of the woman will justify. It may be a question whether this can be best done by means of our homeopathic remedies, or by means purely mechanical, or by a proper mixture of the two. Pulsatilla has a great influence here, but judgment must be used in regard to the potency for any particular case, from the very lowest in some cases to extremely high in others. The process preceding extrusion of these foreign substances is one of fatty degeneration. The layer of cells next to the mucous coat of the uterus become fatty and so lose their hold, and the part peels off, leaving a clean and healthy surface. The action of pulsatilla is to promote this resolution by fatty degeneration, and when this can be brought about in this way, either by the use of pulsatilla, or some remedy more distinctly called for by the subjective symptoms, it is certainly very much better than any mechanical aid could possibly be, for the reason that the original cause of the miscarriage is rarely purely local. It depends upon causes and conditions outside of the uterus, and the remedy indicated by the symptoms will help all these conditions, and restore the whole economy to a healthful state. There are many cases in which there are no indications for a remedy, and where from the surroundings of the case, sanitary or otherwise, it is desirable to clean out the uterine cavity at once without delay, and where the injury from mechanical interference is less than the probable ill consequences of leaving the case to a possible natural evolution. In most of these cases the use of the fingers is all that is necessary, though the finger must be a trained one, and the novice cannot expect to do thorough work. Even the experienced finger will not always be able to completely empty the cavity of all shreds, and recurrent hemorrhages may drive the physician at last to the use of the curette. One is to choose in these cases, as elsewhere, whether he will make his chief reliance upon his medicine case or his instrumental case. One can hardly be an expert worker in both. If one is to use homeopathic remedies with precision, he must have become expert in their use by practice. It is precisely the same in the use of the curette, which is a safe instrument in the hands of a capable surgeon, like Professor Leavitt, but is an exceedingly dangerous weapon in the hands of a novice.

PROFESSOR LEAVITT is a believer in not only an immediate repair of the perineum, but of cervical lacerations as well. He says that "they should be repaired immediately if at all." Here again an experienced man like Professor Leavitt has the advantage. It is not an easy thing in the first place to determine at once whether the cervix is really lacerated or not. It is dilated and soft just after the birth; it is spongy and flabby and as you sweep your finger about its circumference there will be found where there are no lacerations an irregularity of the uterine edge. If, however, there is a decided depression at any one particular point, this probably indicates a laceration. Unless one is skillful in making repair it will generally be better, for the patient, to leave this one alone. But anyone who has had experience in repairing the perineum, and can do it neatly and successfully, can do this operation, which is really quite simple; its difficulty being the narrow space in which one has to work, and the fact that these tissues tear easily just at this time. The repair can be made by means of the catgut continuous suture, starting at the uppermost point of the laceration, and taking the stitches rather close together, but not drawing them very tightly until you come down to the very margin of the os.

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THE question of mastitis after confinement was ably discussed by Dr. Custis and others at the Denver meeting. Undoubtedly a large proportion of these cases is caused by permitting the child to pull at the breast before lactation is established. A great many persons have an absurd idea that the babe is born hungry, merely because it cries, and, therefore, should be put to the breast at once. The child is more likely to cry because it is cold, or otherwise disturbed by external influences. The babe who is snugly wrapped up, without being tightly confined, and who is kept warm, will sleep if left alone. It should be encouraged to sleep as nearly continuously as possible for the first few days, by excluding all external influences, such as light and noise, which would disturb it. There will then be no occasion for putting it to the breast, and this factor in the causation of mastitis will be removed. Another important cause of this painful disorder is lack of cleanliness, or any rough handling in

the attempt to make clean. The breast at this time is in a state of nervous and vascular excitement, and is as ready to be touched off into inflammation as a piece of punk against a live coal is to take fire. Abrasions of the nipple are most usually occasioned by these two causes, and abrasion is a wide-open inlet for septic germs. A little alcohol or spirits of wine dabbed on gently and allowed to dry of itself is a good cleansing agent, and of itself tends to destroy floating germs which may alight upon the abraded surface. With so much of external treatment, together with support by a figure-of-eight or other suitable bandage, should the breast become swollen and hot, and inunctions of hot lard, the movement of the hand being downward and outward from the axilla to the nipple, together with the appropriate homeopathic remedy, will surely prevent every case of mastitis. In my own practice, now extending over a period of twenty years, I have never had a case of mastitis, except when I have been called in to see neglected cases, or in consultation, and I am, therefore, very strongly of the opinion that they may be prevented when proper attention is paid to hygienic measures and proper remedial agencies. The remedies most often called for are bryonia, belladonna, phytolacca, and conium, in the order named, though of course many other remedies are useful and may be called for. Graphites in neglected cases is very frequently indicated. It is usually unnecessary to remove the babe from the breast, unless the case has been grossly neglected; though it is often desirable to use a glass nipple shield, if the nursing of the child is painful to the mother. Most cases of mastitis are not septic in origin, but are occasioned by obstruction of the milk in the ducts, and this more frequently from a bad quality of the milk itself. Where the breast has once been lanced in a previous confinement, we are pretty sure to have trouble, though in these cases, by giving previously for a month or so a dose of graphities 30, we ward off this trouble.

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THE question of the ligation of the umbilical cord was also discussed at the Denver meeting. This is one of the subjects which seem never to get settled. Theoretically there is no use of ligating the maternal end, but there are certain practical

advantages, first as to cleanliness, then also the larger the bulk of the placenta the sooner it will be extruded. There are also occasional cases in which, from an untied cord, there will be a continued flow from the maternal end, and this will go on to a dangerous degree. There is no possible harm from tying the cord after it has become pulseless, and it should always be done. For the sake of the child the cord should never be tied or cut until it has become cold. The child needs, and should have all the placental blood that can be pumped into it. Statistics have abundantly proven that the child is more vigorous who is thus treated. The cord should not only be tied before it is cut, but after an interval of half an hour it should be examined, and retied, as hemorrhage frequently occurs two or three hours later from the first knot becoming loose, owing to the shrinkage in diameter of the cord ; and not a few children have bled to death because this was not noticed in time.

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THE dietary of the lying-in woman is an important consideration. No general rule can be laid down, but unless there is fever, the light diet ordinarily recommended is a mistake, and frequently leads to an intermittent fever, which is a result of partial starvation, and which once set up is difficult to overcome. I have seen these cases where the women have been deprived, through over officiousness, of sufficient nourishment during the first ten days after confinement, in which there would be every evening a rise of temperature of one or more degrees Fahrenheit, and which condition seemed impervious to medical treatment, restoration only taking place gradually through forced feeding. It is of course in most cases undesirable for a person in bed to take more food than appetite requires, but it is also desirable to make sure that she is offered, if possible, a sufficient quantity and variety of food presented in an appetizing manner. Women after childbirth are much more likely to suffer from low feeding than from eating too much, and I am careful to take great pains to secure those kinds of food which the patient herself particularly likes. Nor is it necessary, in this connection, to avoid articles of diet which are popularly supposed to be bad for a babe. The food is varied as to the relative quantity of solids

and liquids according to the nature of the breast milk, until the flow of milk is full. Hot liquids should be given, and these should be nourishing as well as hot; afterward the quantity of the flow can be nicely regulated by varying the proportions of the mother's diet. The amount of thought expended on this subject is well repaid by the increased strength of the patient, and by the fact that when she does get out of bed, she is stronger and more buoyant than she has been for some months previously. Slow convalescence may depend upon many things, but the most frequent cause in lying-in women is lack of suitable nourishment, in sufficient quantity, during the first ten days after the birth of the child.

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**W**ET nurses are not so important a part of urban life in this country as they are in Europe. Fortunately, a large portion of our women are still willing to nurse their own children. In those cases, however, in which a wet nurse proves necessary, the question of diet is an important one, and yet this is entirely ignored in the text-books on the subject. In Paris, where the wet nurse is an important adjunct to civilization, it has been the habit to give a full diet comprising a large allowance of meat and wine. As many of these nurses come from the country, where their diet consisted principally of vegetables, their health soon becomes affected by this overindulgence in hearty food. She grows fat, breast becomes flaccid and gives an inadequate supply of milk, which is often of poor quality. Dr. Constantin Paul has recently made a study of this subject and advises against any sudden change of diet on the part of the nurse, trying to furnish her with about the same quality and sort of food that she has been habituated to. This régime has been attended with excellent results.

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**S**EVERAL cases of placenta prævia have recently been treated at the hospital at Berlin successfully by the introduction into the cavity of the uterus after artificial rupture of the membrane of a bag which is afterward distended with water and maintained in close contact with the lower segment of the uterus by means of continuous traction on the tube. This intra-uterine bag invari-



ably arrests hemorrhage from the placenta and permits of dispensing with podalic version after Braxton and Hickson's method, an operation which presents the inconvenience of being difficult to execute, and of being attended by excessive fetal mortality. The first thing to do is to rupture the membranes. In cases in which the latter lie directly against the head of the fetus in the presence of a placenta *pævia centralis*, which must be perforated, this maneuver is sometimes difficult to carry out. As soon as the membranes are ruptured the rubber bag, carefully disinfected, emptied, and folded, is introduced, being held with a pair of self-locking forceps, thus easily passing through the cervical canal, provided the latter is dilated enough to admit a finger. When the bag has cleared the internal orifice of the cervix the forceps are opened and carefully withdrawn, while the finger of the accoucheur, introduced in the cervical canal, prevents the bag from following it. The bag is thereupon filled by an assistant with water—never with air, inasmuch as the latter might be the means of causing an embolism in case the rubber bag should break, which is not beyond the range of possibility. The bag filled and the stopcock closed, the accoucheur exerts on the tube fitted to the bag a traction sufficiently energetic to stop completely the flow of blood, while a loop is made out of any kind of cord and tied at the foot of the bed. Through this loop is passed the tube of a *colpeurynter*, the tube being then stretched as much as possible without causing pain to the patient, and fastened in such a manner as to exert a continuous automatic pressure of the apparatus. It is obvious that the traction thus established on the intra-uterine bag should be applied as far as possible in the direction of the pelvic axis. By compressing the placenta the intra-uterine bag completely stops the hemorrhage, while through the pressure exerted on the lower segment of the uterus it provokes contractions of this organ and dilatation of the cervix, exactly as under normal conditions. After a time varying between fifteen minutes to three hours the contractions of the uterus usually determine spontaneous expulsion of the bag through the dilated cervix, the bag following into the vagina and from which it is immediately extracted. The subsequent conduct of the case must be governed by the attending circumstances. When the sponta-

neous expulsion of the bag is not followed by hemorrhage—that is to say, when the part of the fetus presenting is sufficiently engaged in the cervix of the uterus—delivery is allowed to take its natural course. If, on the contrary, the flow of blood persists the accoucheur proceeds immediately to extract the fetus. Of the six cases so treated all the parturients recovered, while of the children only one died. In fact this latter was evidently dead before labor began.

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DR. LEHMANN recently showed at the Berlin Medical Society the placenta of a woman who was delivered last December, which showed the typical tubercular lesions. The child died ten days after birth, but no evidence of tuberculosis was found on any of the organs on *post-mortem* examination. The child, however, seems to have died from what might be called lack of viability.

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#### NOTES ON CURRENT LITERATURE.

AT this time of the year one of the more common complaints with which the physicians have to deal is cough. This is often an isolated symptom, which comes on at the beginning of cold weather and lasts until the following spring. This sort of cough is difficult to deal with, and never can be cured by routine treatment. Besides these and other forms of chronic cough, there are the various symptoms connected with taking cold of which cough is a most prominent one, and the one from which the patient demands immediate relief. They come to us and want something for the cough, and unless the prescription alleviates what to their mind is the principal condition within a few hours, or a day or two, they look upon it as of no good. The physician knowing this is tempted to give palliatives because of the difficulty in selecting a true homeopathic remedy. Nothing is so difficult to prescribe for as an obvious or common symptom, and patients rarely make that nice distinction in detailing their symptoms that is required, in order that a proper prescription may be made in their case. To them a cough is usually just a

cough, and nothing more. To help us out in this emergency some ten years ago, Dr. Lee published a small work on cough and expectoration. This has formed the basis of a new work by Dr. George H. Clark which is now offered to the profession in which is gathered up all the information in our materia medica, in regard to cough and its accompanying symptoms. The work is beautifully printed, and bound in flexible leather, making it a very handy book to consult. Those who will take the trouble to study their cases accurately and make a proper prescription will find this book of great value to them<sup>1</sup>.

Another work by another Dr. Clarke, a discussion as to what homeopathy is, has recently been issued.<sup>2</sup> Dr. John H. Clarke of London is too well known to the medical profession as a writer to need any introduction. He has written a little book which sets forth in an admirable way the cause of homeopathy. It is addressed to the laity, but is good reading for anybody. Even in these days when homeopathy has become so widespread, the physician is constantly met with a most egregious misunderstanding as to the true nature of the science of homeopathy. This little book makes fresh to his own mind the best rejoinders that can be given to criticism upon homeopathy, and a perusal of it will put anyone in a better position to meet the question and comments which he hears continually on every hand. The book can be put into the hands of any seeker after medical truth with advantage, and the more the physician does to make the principal of cure understood in his neighborhood, the stronger his professional position will be. Dr. Clarke's work is a small one, but is full of meat, it will good wherever it is introduced, and I hope it will have a large sale in this country. It may be purchased through any of the homeopathic pharmacies.

<sup>1</sup>LEE AND CLARK'S COUGH AND EXPECTORANT. A Reportorial Index of their Symptoms. By GEORGE H. CLARK, M. D. New York : A. L. Chatterton & Co., 1894.

<sup>2</sup>HOMEOPATHY: ALL ABOUT IT; OR, THE PRINCIPLE OF CURE. BY JOHN J. CLARKE, M. D., 12 Warwick Lane, Paternoster Row, E. C., 1894.

# INDEX.

---

- A** CUTE Pulmonary Diseases of Children, Duty of the Physician in the Management of the. F. E. Downey, 420  
Adenitis. Non-specific Inflammation of Lymphatic Glands. Robert N. Tooker, 162  
Albuminuria in Children, 94  
Analogy between Menstruation and the Puerperal State, 544  
Anterior Ventral Fixation of the Uterus, Report on Seven Cases of. W. H. Wathen, 159  
Applying the Caутery to Endometrium as a Means of Arresting Hemorrhage, 475  
Artificial Foods for Infants. Jos. P. Cobb, 441  
Awkward Gait of Children, 91  
**B** AILEY, BENJ. F. Puerperal Fever, 221  
Bandage and Douche in Obstetrical Practice. E. E. Vaughan, 284  
BECKWITH, D. H. How to Improve Children of the Future, 503  
BERGEN, E. D. A Case of Obstetrics, with a Peculiar Complication, 279  
BLIEM, MILTON J. Dystocia from Shortened Cord, 413  
Movable Kidney in Woman, 316  
BRICKLEY, LAURA C. Some Don'ts for Babies, 568  
BROOKS, E. D. Rupture of the Uterus Complicating Parturition, 514  
BROWN, M. BELLE. Indications and Contra-Indications for Trachelorrhaphy, 32  
**C** ANCER with Sciatica, 546  
Carelessness in the Use of Electricity, and a Case, 476  
CARTLICH, J. W. Efficacy of the Similimum in Labor, 245  
Cause of Laceration of the Perineum, 575  
Cervical Lacerations, 577  
CHANEY, E. N. Neurasthenia of Children, 493  
CHAPMAN, MILLIE J. Neuroses of Childhood, 47, 187  
Prevention of Deformities, 500  
Choose your Father and Mother, 86  
Chorea in Pregnancy. E. M. Hale, 229  
Clinical Case. E. E. Snyder, 402  
CLOKEY, ALLISON, Rigid Os Uteri, 354  
COBB, JOS. P. Artificial Foods for Infants, 441  
Contagion, a Cause of, 390  
in our Public Schools, 92  
in our Public Schools and its Prophylaxis. Lucy C. Hill, 75  
CORY, HARVEY W. Infantile Spinal Paralysis, 435  
Cough and Expectorant, 581  
CUMMINGS, J. C. Diet in Pregnancy, 241  
CUSTIS, J. B. GREGG. Hemorrhage from the Breast, 333  
Cutting the Cord, 81

Cystospasm, 481

Cystospasm, Dewitt G. Wilcox, 399

**D**AILY, J. C. Electricity: Its Place in Gynecology, 287

Daughters of Esculapius, 83

DE BAUN, EDWIN. A Prolapsed Inverted Uterus, 74

DESCHERE, MARTIN. Some Views on Vaccination, 103

Devastating Effects of Pus, 462

Dictionary, A Medical, 98

Dietary of Lying-in Woman, 580

Diet in Pregnancy. J. C. Cummings, 241

Diphtheria, A Prophylactic for, 385

Diphtheria, The Prevention of. Wm. A. Seibert, 180

Discussion of Dr. Runnels' Article on Fecal Retention. C. E. Sawyer, 382

Double Vaginas. A. Lenora White, 154

DOWNNEY, F. E. The Duty of the Physician in the Management of the Acute Pulmonary Diseases of Children, 420

Dressing the Cord, 81

Dystocia—A Rare Case. S. P. Hedges, 340

Dystocia from Shortened Cord. Milton J. Bliem, 413

**E**ARLY Diagnosis of Rachitis, 90

Effect of Inoculation, 192

Efficacy of the Similimum in Labor. J. W. Cartlich, 245

Electricity and Diagnosis Considered, 476

in Gynecology, A Place of, 471

Its Place in Gynecology. J. C. Daily, 287

Emergencies of Anæsthesia. W. S. Smith, 133

Enterocolitis. Julia C. Jump, 51

Ergot, the Use of in Labor, 575

Evils Attending the American Operation. James C. Wood, 369

Excision of the Uterus for Suspected Malignant Disease. Wm. Davis Foster, 322

**F**ALSE Conception, A Case of. M. W. Vandenburg, 144

Fecal Retention. Moses T. Runnels, 378

Forceps as a Conservator of the Child. J. C. Sanders, 208

Foreign Bodies in the Ear, 387

FOSTER, WM. DAVIS. Excision of the Uterus for Suspected Malignant Disease, 322

FRALICK, WILFRED G. Vesico-Vaginal Fistulæ. Preparatory Treatment in Cases of Long Standing, 148

Frequency with which Smallpox Appears, 191

FURBER, M. L. Postural Treatment in Diseases of Women, 349

**G**LUTEN Bread, 387

Gonorrheal Salpingo-Ovaritis, 556

GREEN, W. E. Pelvic Surgery, 327

Vaginal Hysterectomy for Carcinoma Uteri, with Report of Case, 26

GUTHERZ, LIZZIE GRAY. Woman's Steadfast Friend, 410

Gynecological Operations. A Consideration of, as a Measure of Relief in some Perversions of the Nervous System. S. H. Knight, 269

Gynecologic Prophylaxis. Rebecca W. Rogers, 309

- Gynecology, A Text-Book on. J. C. Wood, 196  
 The Relation of, to Materia Medica, 485
- H**AHNEMANN'S Chronic Diseases, 100
- HALE, E. M. Chorea in Pregnancy, 229  
 Dystocia Due to Short Cord, 537  
 Intra-Uterine Injections of Tincture of Iodine in  
 Endometritis with Hemorrhage, 19
- Headaches of Children, 93
- HEDGES, S. P. Dystocia—A Rare Case, 340
- Hematemesis, A Case of, 464
- Hemorrhage from the Breast. J. B. Gregg Custis, 333
- HICKOX, KATE L. Two Babies, 250
- HIGBEE, CHESTER G. Report on Official Surgery Based on  
 Analysis of One Thousand Cases; Read at the Homeopathic  
 Medical Congress, 69
- HILL, LUCY C. Contagion in our Public Schools and its Pro-  
 phylaxis, 75
- HINKLE, ABBIE, H. Use and Abuse of Pessaries, 517
- Homeopathy in Pregnancy, 87  
 or the Principal of Cure, 582
- How an Abscess may become Infectious, 465
- Hydrocephalus of the Fetus. F. M. Martin, 255
- Hygiene of Pregnancy, 85
- Hysteric Fever, 102
- I**NDICATIONS and Contra-Indications for Trachelorrhaphy.  
 M. Belle Browne, 32
- Indications of Uterine Displacements with their Non-Surgical  
 Treatment. J. C. Jump, 232
- Infantile Pneumonia Simulating Meningitis, with Some Diagnos-  
 tic Phenomena. C. H. Thomas, 169
- Inflammation, a Battlefield, 465
- Infanticide, A Singular Method of, 198
- Infection, The Line of, 464
- Insanity from the Abuse of Indian Hemp, 198
- Intra-Uterine Injections of Tincture of Iodine in Endometritis  
 with Hemorrhage. Edwin M. Hale, 19
- Inversion of the Uterus, 101
- J**ANNEY, O. EDWARD. Some Problems in the Care of  
 Infants, 43  
 The Paralysis of Diphtheria, 416
- JUMP, JULIA C. Enterocolitis, 51  
 Indications of Uterine Displacements with their Non-  
 Surgical Treatment, 232
- Juvenile and Hereditary Epistaxis, 386
- K**ASSELMAN, H. C. Post-partum Hemorrhage, 344
- KNIGHT, S. H. A Consideration of Gynecological Opera-  
 tions as a Measure of Relief in some Perversions of  
 the Nervous System, 269
- L**ACERATED Perineum, Immediate Repair of, 572
- LEAVITT, SHELTON. Pratt's Method of Vaginal Hyster-  
 ectomy, 259  
 Technique of Immediate Perineorrhaphy, 487

- LEE, J. M. The Surgical Treatment of Retro-displacements of the Uterus, 295
- Ligation of the Umbilical Cord, 579
- Limitations of Electricity's Usefulness, 478
- LOGAN, GEORGE. Puerperal Convulsions, 145
- MC ELWEE, L. C. Occipito-Posterior Positions, 211
- MARTIN, F. M. Hydrocephalus of the Fetus, 255
- MARTIN W. J. Phthisis Pulmonalis as a Sequel of Measles, 171
- Mastitis after Confinement, 578
- Materia Medica, 99
- MILLSOP, SARAH J. The Importance of more thorough After-Care of the Parturient Woman, 426
- Miscarriage, Care of the Uterine Cavity after, 576
- Movable Kidney in Women. Milton J. Blim, 316
- MUDGE, KATE G. Progress in Gynecology, 21
- Mumps, Period of Incubation in, 389
- NAVEL and Cord, The Care of the, 80
- Navel Dressing. J. C. Sanders, 247
- NEATBY, EDWIN A. The Neuroses of Childhood, 56
- Necessity of Orificial Work after Confinement. H. P. Skiles, 359
- Neurasthenia. J. B. Westcott, 455
- Neuroses of Childhood. Edwin A. Neatby, 56
- Millie J. Chapman, 47, 187
- New, Safe, and Sure Method to Expedite Difficult Labor, 100
- NICHOLS, F. S. Prophylactics in Disease in Children, 531
- Nitrous Oxide Gas, 197
- NOTTINGHAM, J. C. Practical Philosophy, 38
- Sexual Errors, 449
- OBSTETRICAL Observations. C. A. Weirick, 215
- Surgery. G. F. Washburne, 362
- Surgery. Wm. C. Richardson, 218
- Obstetrics, A Case of, with Peculiar Complications. E. D. Bergen, 279
- Occipito-Posterior Positions. L. C. McElwee, 211
- O'CONNOR, JOSEPH T. Organic Nervous Affections of Infancy and Childhood, 9
- Opposition to Homeopathic Remedies, 193
- Organic Nervous Affections of Infancy and Childhood. Joseph T. O'Connor, 9
- Orificial Surgery, Report on. Based on Analysis of One Thousand Cases; Read at the Homeopathic Medical Congress, Chester G. Higbee, 69
- ORLEMAN, E. LOUISE. The Physical Decadence of Women and its Results, 406
- OSTROM, HOMER I. The Preparatory Treatment for Abdominal Operations, 127
- Ovarian Prolapse, 550
- PARALYSES of Diphtheria. O. Edward Janney, 416
- PARKER, ANNA M. Abortion from a Malformed Uterus, 528
- Parturient Woman, The Importance of more thorough After-Care of the. Sarah J. Millsop, 426

- PECK, GEO. B. Puerperal Dietetics, 391  
 Pelvic Surgery, 461  
     W. E. Green, 327  
 Phthisis Pulmonalis as a Sequel of Measles. W. J. Martin, 171  
 Physical Decadence of Women and its Results. E. Louise Orleman, 406  
 Post-partum Hemorrhage. H. C. Kasselmann, 344  
 Postural Treatment in Diseases of Women. Anna M. L. Furber, 349  
 POZZI, SAMUEL. Ablation of the Fallopian Tubes, 565  
 Practical Midwifery, 96  
     Philosophy. J. C. Nottingham, 38  
 Pratt's Method of Vaginal Hysterectomy. Sheldon Leavitt, 259  
 Prenatal Medication, 82  
     Treatment for Easy Childbirth, 88  
 Preparatory Treatment for Abdominal Operations. Homer I. Ostrom, 127  
 Preventions of Lacerations of the Perineum, 574  
 Progress in Gynecology. Kate G. Mudge, M. D., 21  
 Prolapsed Uterine Fibroid, 548  
 Puerperal Convulsions. George Logan, 145  
     Fever. Benj. F. Bailey, 221  
     (Uræmic) Convulsions. Wm. I. Tyler, 281  
**R**ACHITIS, 89  
 Random Thoughts on Obstetric Practice. Silas C. Whitcomb, 351  
 Recent Progress in Gynecology. Moses T. Runnels, 199  
 REED, WM. CASH. Uterine Hemorrhage, 543  
 RICHARDSON, WM. C. Obstetric Surgery, 218  
 Rights of the Homeopathic Physician, 194  
 Rigid Os Uteri: A Case. Allison Clokey, 354  
 ROGERS, REBECCA W. Gynecologic Prophylaxis, 309  
 RUNNELS, MOSES T. Fecal Retention, 378  
     Recent Progress in Gynecology, 199  
     Os Uterine Expiration, 301  
**S**ANDERS, J. C. Navel Dressing, 247  
     The Forceps as a Conservator of the Child, 208  
 SAWYER, C. E. Discussion of Dr. Runnels' Article, 382  
 SEIBERT, WM. A. The Prevention of Diphtheria, 180  
 Sexual Errors. J. C. Nottingham, 449  
 SHERMAN, NANCY B. From What do the most frequent Complications of Obstetrics and Gynecology Arise, 534  
 SKILES, H. P. The Necessity of Orificial Work after Confinement, 359  
 SLIGHT, B. H. B. The Feeding of Sick Children, 491  
 Smallpox and the Red-chamber Method of Treatment, 385  
     The Treatment of. George William Winterburn, 114  
 SMITH, W. S. The Emergencies of Anæsthesia, 133  
 SNYDER, E. E. A Clinical Case, 402  
 Some Problems in the Care of Infants. O. Edward Janney, 43  
 SOUTHWICK, GEORGE R. A Case of Ruptured Tubal Pregnancy.  
     Operation, Recovery, 524



- SPALDING, HENRY EDWIN. The Value of the Curette in Obstetrics, 538
- STREETER, JOHN W. Unusual Cause of Ascites, 423
- Surgical Treatment of Retro-displacements of the Uterus, 295  
of Tubercular Peritonitis, 466
- T**HE Influence of Fright on Diphtheria Patients, 388  
Theory and Practice, 97
- Therapeutic Side, 469
- Therapeutics of Pregnancy, 86
- THOMAS, C. H. Infantile Pneumonia Simulating Meningitis, with some Diagnostic Phenomena, 169
- TOOKER, ROBERT M. Adenitis. Non-specific Inflammation of Lymphatic Glands, 162
- Two Babies. Kate L. Hickox, 250
- Tubercular Peritonitis. Two Cases in One Family, 470
- TYLER, WM. I. Puerperal (Uræmic) Convulsions, 282
- Typhoid Fever, A Cause of, 388
- U**NUSUAL Causes of Ascites. John W. Streeter, 423
- Uterine Extirpation. O. S. Runnels, 301  
Fibroids in General, 549  
Fibroids, The Treatment of, 472  
Hemorrhage Associated with Pregnancy, 545
- Uterus, Prolapsed Inverted. Edwin de Baun, 74
- V**ACCINATION and Smallpox, 191  
A Protection, 192  
Some Views on. Martin Deschere, 103
- Vaginal Hysterectomy for Carcinoma Uteri, with Report of Case. W. E. Green, 26
- VANDENBURGH, A. M. A Case of False Conception, 144
- VAUGHAN, E. E. The Bandage and the Douche in Obstetrical Practice, 284
- W**ASHBURN, G. F. Obstetrical Surgery, 362
- WATHEN, W. H. Report on Seven Cases of Anterior Ventral Fixation of the Uterus, 159
- WEIRICK, C. A. Obstetrical Observations, 215
- WESTCOTT, J. B. Neurasthenia, 455
- WHIPPLE, A. A. The Use and Abuse of Obstetric Forceps, 510
- WHITCOMB, SILAS C. Random Thoughts on Obstetric Practice, 351
- WHITE, A. LENORA. Double Vaginas, 154
- Why does Primary Perineorrhaphy so often Fail? George William Winterburn, 374
- WILCOX, DEWITT G. Cystospasm, 399
- WINTERBURN, GEORGE WM. The Treatment of Smallpox, 114  
Why does Primary Perineorrhaphy so often Fail? 374
- Woman's Steadfast Friend. Lizzie Gray Guthertz, 410
- WOOD, JAMES C. The Evils Attending the American Operation, 369

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